FOR ARGUMENT

IN THE

Supreme Court of the United States

OCTOBER TERM, 1979

No. 79-5

JEFFREY C. MILLER, Acting Director, Illinois Department of Public Aid,

Appellant,

v.

DAVID ZBARAZ, M.D., MARTIN MOTEW, M.D., on their own behalf and on behalf of all others similarly situated; CHICAGO WELFARE RIGHTS ORGANIZATION, an Illinois not-for-profit corporation, and JANE DOE, on her own behalf and on behalf of all others similarly situated,

Appellees.

ON APPEAL FROM THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF ILLINOIS,
EASTERN DIVISION

REPLY BRIEF OF APPELLANT MILLER

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I.

THE CONDITIONS FOR REVIEW OF THE CONSTITUTIONALITY OF THE HYDE AMENDMENT AND PRIOR STATUTORY RULINGS OF THE SEVENTH CIRCUIT AND THE DISTRICT COURT HAVE BEEN MET IN THIS CASE

A.

The Hyde Amendment Was At Issue In The Proceedings Below.

Plaintiffs and the United States assert that the District Court was without jurisdiction over the validity of the Hyde Amendment because there was no "case or controversy" as mandated by Article III, § 2 of the Constitution. This position ignores the fact that all defendants placed the Hyde Amendment at issue by moving for summary judgment pursuant to FED.R.CIV.P. 56 based upon the constitutionality of the federal statute. Since the defendants placed the Hyde Amendment at issue by their pleadings, it is clear that the argument of the plaintiffs and the United States rests on the proposition that there can be no "case or controversy" over an issue unless it is expressly raised as a part of plaintiffs' cause of action within the parameters of the complaint.

Article III, however, confers jurisdiction over "cases" and not merely claims or causes of action. *See, Aldinger* v. *Howard,* 427 U.S. 1, 13-14 (1976); *cf., United States* v. *Memphis Cotton Oil Co.,* 288 U.S. 62, 67-68 (1933); *Baltimore S.S. Co.* v. *Phillips,* 274 U.S. 316, 321 (1977). The inquiry as to whether a claim for relief qualifies as a case "arising under . . . the Laws of the United States" is distinct from the question of whether various "claims" constitute a "case" for jurisdictional purposes. *United Mine Workers of America* v. *Gibbs,* 383 U.S. 715, 725 n.12 (1966). Indeed, this Court has recognized that the boundaries of a constitutional "case" are not limited to the face of plaintiffs' complaint. *See, Continental T.V., Inc.,* v. *GTE Sylvania, Inc.* 433 U.S. 36, 40 (1977); *Beacon Theatres, Inc.* v. *Westover,* 359 U.S. 500, 502-03 (1959). Acceptance of plaintiffs' argument would effectively preclude a defendant from ever raising affirmative legal defenses and would prevent a district court from hearing compulsory counterclaims, FED.R.CIV.P. 13(a), or cross claims, FED.R.CIV.P. 13(g). In the absence of Congressional intent to the contrary, this Court should not sanction a rule which limits the jurisdiction of

federal courts to the express claims and relief sought within the four corners of plaintiffs' complaint. *See, Owen Equipment & Erection Co.* v. *Kroger,* 437 U.S. 365 (1978); *Aldinger* v. *Howard,* 427 U.S. 1 (1976); *Kahn* v. *International Paper Co.,* 414 U.S. 291 (1973).

Plaintiffs and the United States also ignore the fact that any claim for relief under Title XIX of the Social Security Act, 42 U.S.C. § 1396 *et seq* regarding funding for abortions necessarily required the court to interpret the intent of Congress in enacting the Hyde Amendment. As was stated in another setting, "Congress did not intend to confine the jurisdiction of federal courts so inflexibly that they are unable to protect legal rights or effectively to resolve an entire, logically entwined lawsuit." *Owen Equipment & Erection Co.* v. *Kroger, supra,* 437 U.S. at 377. Because of the federal funding restrictions present in the Hyde Amendment, on the one hand, and federal funding obligations present in Title XIX, *see,* 42 U.S.C. § 1396b(a) & § 1396d(b), on the other hand, the validity of the state law at issue here is inextricably and "logically entwined" with that of the Hyde Amendment.

Plaintiffs, however, rely on *Moore* v. *Charlotte-Mecklenburg Board of Education,* 402 U.S. 47 (1971) and suggest that because "[t]he United States and Illinois agree that the Hyde Amendment is constitutional" there is no Article III case or controversy. Brief for Appellees, p. 30. Plaintiffs ignore the fact that the infirmity found by this Court in *Moore* was that "both litigants desire[d] precisely the same result", 402 U.S. at 48. Here, there is an essential antagonism between plaintiffs and the state defendants based upon the logical relationship between P.A. 80-1091 and Hyde. Moreover, the interests of the United States and the State are, in part, adverse. After the District Court had declared both the Hyde Amendment and P.A. 80-1091 unconstitutional, Defendant Quern filed a motion to require federal reimbursement for all "medically necessary" abortions which were required to be funded under

the Final Judgment Order. The United States flatly opposed this motion, and refused to pay for any non-Hyde Amendment abortions. To this day, Illinois has received no federal financial reimbursement for non-Hyde Amendment abortions it has funded as a consequence of the April 30, 1979 Judgment Order. Hence, the requisite "adverseness" regarding the Hyde Amendment is present.[1]

B.

The Court May Review All Prior Statutory Rulings Below.

Moreover, by finding that the Hyde Amendment is properly before this Court within this case, the Court, as a result of its rulings here and in *Harris* v. *McRae,* No. 79-1268, will be in a position to promote judicial economy by resolving the entire spectrum of Title XIX and Hyde Amendment abortion-related controversies presented in both cases. This includes clarification of the Seventh Circuit's statutory analysis which prefaced its holding that the Hyde Amendment constituted a substantive modification of Title XIX. Defendant's basis for seeking review of the Seventh Circuit's ruling still primarily rests upon his contention that an appeal under 28 U.S.C. § 1252 brings up the "whole case", Brief of Appellant Miller, pp. 25-31, and particularly upon the observation by this Court that its power of review where jurisdictional requirements are otherwise satisfied extends to "all other questions arising on the record, including those passed upon by the circuit court of appeals." *Union Trust Co.* v. *Westhus,* 228 U.S. 519, 522 (1913). Should the Court, however, deem it inappropriate to rely on the "whole case" concept, Defendant Miller submits

[1] Equally significant, is the purported reversal of long-standing HEW interpretation of Title XIX requirements by the present Secretary of HEW "promulgated" for the first time in the Brief of the United States, pp. 43-44, n.23. This interpretation regarding the concept of "medical necessity" has evoked a heated controversy between the states and HEW. *See* discussion, Part II, *infra.*

that the Judgment Order of April 30, 1979 [Jurisdictional Statement, A43-A48], which is without question subject to court review, has incorporated the prior rulings of the Seventh Circuit and the District Court on the statutory issues. Thus, the Final Judgment Order provides, *inter alia:* "the District Court's previous May 15, 1978 Judgment and its June 13, 1978 Judgment, *as modified by this February 15, 1979 Order, remain in force;*" (emphasis added) p. A43; and " 'Illinois' restrictive abortion funding policy' means the policy Illinois adopted pursuant to P.A. 80-1091, ILL.REV.STAT.SUPP. (1977), ch. 23, §§ 5-5, 6-1, 7-1, *as modified by the District Court Order of February 15, 1979"* (emphasis added), p. A44. See, ¶ 4(a)(i) of the Judgment Order which employs the term "Illinois' restrictive abortion funding policy" and grants partial summary judgment to the plaintiffs by invalidating P.A. 80-1091. *Id.* As incorporated, the earlier injunction order has merged with the Final Judgment Order and is accordingly fully reviewable. Defendant Miller's fourth question presented in his Jurisdictional Statement reflects his intention to seek review of the statutory issues and thus all the conditions for such review have been satisfied.

Since there is still a controversy regarding the proper interpretation of Title XIX without regard to the Hyde Amendment, this Court should resolve that question.[2]

[2] *Cf., Quern* v. *Mandley,* 436 U.S. 725 (1978), 98 S.Ct. 2068, 2074 n.7: "State's decision to withdraw voluntarily from the § 406(e) program in no way mooted the Court of Appeals' prior determination that the program was being operated in violation of federal law. . . . [Defendant's decision to withdraw] could not operate to deprive the successful plaintiffs, and indeed the public, of a final and binding determination of the legality of the old practice. *United States* v. *W. T. Grant Co., supra,* 345 U.S. at 632, 73 S.Ct., at 897."

II.

CONTRARY TO THE INTERPRETATION OF THE CURRENT SECRETARY OF HEALTH, EDUCATION AND WELFARE, TITLE XIX CONTAINS NO "MEDICAL NECESSITY" LIMITATION ON STATE DISCRETION OVER THE SCOPE AND EXTENT OF MEDICAL ASSISTANCE BENEFITS.

In a footnote which warrants the Court's most careful scrutiny, the Secretary, through the Solicitor General, makes the following statement:

> In establishing the Medicaid program in 1965, Congress required participating states to pay, at minimum, for services in five mandatory categories, including inpatient and outpatient hospital services and physicians' services . . . [citations omitted]. In light of the importance Congress attached to the provision of services within the mandatory categories . . . [citations omitted], *the Secretary of HEW has interpreted the Medicaid Act to require participating states to fund medically necessary care falling within those categories.* In particular, an HEW regulation precludes denial or reduction of payments, for medically necessary services falling within any of the five mandatory categories, solely on the basis of "diagnosis, type of illness, or condition." 42 C.F.R. 440.230(c)(1). *The statute and regulation would be violated if a state were to single out medically necessary abortions for exclusion from coverage,* because such action by a participating state would constitute a denial of payments based solely on diagnosis (*i.e.,* that an abortion is medically necessary) and condition (*i.e.,* pregnancy)
>
> *The statutory requirement that each state Medicaid plan "include reasonable standards * * * for determining eligibility for and the extent of medical assistance under the plan" (42 U.S.C. 1396a(a)(17)(A)) does not authorize an otherwise prohibited exclusion of therapeutic abortions from coverage.* That statutory provision . . . was not intended to permit states to refuse payments on the basis of the kind of condition for which treatment is needed or the kind of medically necessary services within any of the five mandatory categories for which benefits are sought . . .
>
> *Recognizing that the stated purpose of the Act is to provide "necessary medical services" (42 U.S.C. 1396) . . . [the Secretary has not] authorized participating states to eliminate coverage of a particular kind of medically necessary care.* (Emphasis added)

Brief for the United States at 43-44, n. 23.

Illinois and the amici states argued in their initial briefs that Title XIX on its face imposes no such requirement on participating states and that the legislative history, when read in its historical context, discloses no such intention on the part of the Congress. Director Miller submits that appellees and the Secretary's arguments to the contrary amount to an heroic effort to resuscitate an analysis which expired with the First Circuit's opinion in *Preterm Inc.* v. *Dukakis,* 591 F.2d 121 (1st Cir. 1979), *cert. denied, sub nom., Preterm, Inc.* v. *King,* ____ U.S. ____, 99 S. Ct. 2181 (1979). Illinois' concern in this portion of its reply is to point out to the Court that the Secretary's has *in fact* approved numerous state plan provisions which conflict with the representations and interpretations contained in footnote 23. Thus, her views, erroneous as a matter of law for the reasons previously discussed, Brief of Appellant Miller, pp. 45-55, are not entitled to the deference this Court has afforded them in previous cases. *E.g., Beal* v. *Doe,* 432 U.S. 438, 447 (1977) (deference to agency construction); *New York Department of Social Services* v. *Dublino,* 413 U.S. 405, 420-21 (1973) (established and consistent policy entitled to deference absent "compelling indications that it is wrong . . ."). Indeed, it is HEW's plan approval actions, and not its litigation justifications as voiced by the Solicitor General, which should control. *See Quern* v. *Mandley,* 436 U.S. 725, 738 (1978) ("by approving state plans that cover [certain benefits] HEW has expressed its view that such items are properly included [in state a plan] . . ."); *Citizens to Preserve Overton*

Park v. *Volpe,* 401 U.S. 402, 419 (1971) (criticizing "litigation affidavits" as "merely *post hoc* rationalizations" inadequate to determines the factual basis of agency action).

Title XIX requires the Secretary to "approve any plan which fulfills the conditions specified in subsection (a) of this section . . ." 42 U.S.C. § 1396a (1976). Pursuant to Congress's directive, and despite the Secretary's post hoc averments to the contrary in footnote 23, the Secretary as of March, 1980, had approved fourteen state plan amendments limiting benefits for medically necessary abortion services.[3] For examples of such state plan amendment approvals, see reproduced portions of the Kansas plan, 37a-38a, *infra* and the Kentucky plan, 41a *infra.*

In addition to approving state plan restrictions on abortion benefits, the Secretary has also approved a variety of other specific limitations on the reimbursement of costs related to the provision of health care services falling within the first five subdivisions of 42 U.S.C. § 1396d(a)(1)-(5) (1976). For example, Arkansas limits outpatient visits to twelve per calendar year; Florida limits inpatient hospital services to forty-five days and outpatient services to a maximum of $500 per patient per fiscal year; Georgia will not reimburse the expense of private duty nurses and limits outpatient visits to one per month

[3] Based upon a review of official plan documents currently on file in the offices of the Health Care Financing Administration, Department of Health, Education and Welfare, Woodlawn, Maryland, the following states have approved state plan amendments limiting abortion funding; Connecticut (effective September 1, 1977); Kansas (effective October 1, 1978); Kentucky (effective January 1, 1979); Louisiana (effective April 1, 1978); Maryland (effective January 16, 1980); Minnesota (effective September 18, 1978); Missouri (effective August 2, 1977); Nebraska (effective December 11, 1978); North Carolina (effective date unavailable); Rhode Island (effective October 1, 1978); Vermont (effective January 1, 1980); Virginia (effective July 1, 1979); Wisconsin (effective September 30, 1978); and Wyoming (effective October 1, 1979).

with certain exceptions; Hawaii limits inpatient psychiatric care (but not other forms of inpatient care) to eighteen days; Kansas limits computerized axial tomography (CT scanning) to head scans (other states reimburse the cost of body scans as well); Louisiana limits outpatient visits to three per year with "no provisions for any additional visits"; Nevada limits physician services to two office visits and two therapeutic injections per month; the Northern Mariana Islands does not reimburse occupational therapy costs incurred in an outpatient department; and Puerto Rico and the Virgin Islands reimburse the cost of services only if they are provided in public facilities or, in the case of Puerto Rico, through "two private facilities under contract."[4]

For the limitations included in Illinois' program, the Court is directed to the addendum to Brief of Appellant Miller, pp. 7a-67a.

Illinois submits that the Secretary's approval of these various plan restrictions, some of which are specific to a particular diagnosis (mental illness) or a particular condition (those requiring whole body CT scans or more than two therapeutic injections per month), is additional evidence of the Secretary's traditional willingness to permit individual states to shape their programs of medical assistance under Title XIX to meet their individual needs. This approach, entirely proper under, indeed, required by the provisions of Title XIX, is also inconsistent with the legal position which the Secretary urges through the Solicitor General in footnote 23.

A fuller understanding of the significance of footnote 23 can be gleaned by a perusal of briefs and correspondence filed

[4] Counsel obtained the information summarized in the text in the same manner as the plan provisions governing abortions were accumulated. However, the documents currently on file which counsel reviewed in most cases did not predate 1975. Counsel suggest that a review of earlier plan documents might reveal an even greater variety of approved limitations on the scope of individual state plans.

in conjunction with *Rush* v. *Poythress*, No. 77-2743, *appeal pending* (5th Cir., 1977), a case involving the authority of the State of Georgia and the Secretary of Health, Education and Welfare under Title XIX to refuse to fund "medically necessary" transsexual operations. *See, Rush* v. *Parham*, 440 F.Supp. 383 (N.D. Ga. 1977). In its first brief submitted on behalf of then Secretary Califano, the United States argued that the District Court's ruling that Title XIX required Georgia to fund all transsexual operations deemed medically necessary by a physician was erroneous as a matter of law: (1) The language and legislative intent of Title XIX only require States to utilize reasonable standards and does not compel the coverage of every medical procedure within the categories provided in 42 U.S.C. § 1396d(a)(1)-(5) [the mandatory service categories]; (2) the attending physician's judgment of medical necessity is not controlling on the issue of whether the state must pay for a particular inpatient hospital or physicians' services. See, Brief for the Federal Appellants, pp. 1a-16a, *infra*, filed November 30, 1977.

On April 7, 1980, the United States filed a Supplemental Brief in *Rush* explaining the significance of footnote 23 in its brief herein and withdrawing its argument in Part I of its original brief on Title XIX and medical necessity as far as it applied to the five mandatory service categories. See, pp. 23a-33a, *infra*. Ostensibly, this was done in response to the Secretary's "evolving" ideas regarding Title XIX requirements.[5]

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[5] The Secretary's revisionary, interpretive efforts are exceedingly troublesome not solely because of their impact on state's discretion to limit the amount duration and scope of services in context other than abortions, but because of their potential for altering the breadth and character of the constitutional issues present in this case. Without conceding any of plaintiffs' arguments, it may be easier to sustain an equal protection challenge to a state medicaid limitation where "congressional intent," as gleaned by the Secretary, prohibits the exclusion of particular items of necessary medical care.

However, as the State of Georgia points out in its letter to the Fifth Circuit objecting to the filing of the Supplemental Brief, p. 19a *infra*, "we find footnote 26 [*sic*, 23] a blatant misstatement of fact." As noted above, the Secretary has not only "authorized participating states to eliminate coverage of . . . particular kind[s] of medically necessary care," n. 23, she has authorized state plan amendments placing limits on abortion funding similar to those at issue here, and narrower than then existing Hyde Amendment criteria. The Secretary's interpretation of the reach of § 1396a(a)(17) in footnote 23 ("[§ 1396 a(a)(17)] was designed to afford each participating state a degree of flexibility in determining the coverage of its plan with respect to persons for whom Medicaid assistance is optional") fails to answer Secretary Califano's counter-argument in the original brief in *Rush:*

> [A]ny interpretation of § 1396a(a)(17) to mean that the "reasonable standards" language was intended to guide the state's decision as to whether the optional services should also be covered becomes superfluous. Such an interpretation would strain all principles of statutory construction since the states are allowed to exclude these services without justification and even in the face of reason.

Brief of the Federal Appellants, pp. 9a-10a, *infra*.

Similarly, the Secretary's assertions that her novel interpretation is a true reading of the original intent of Congress in 1965 is undermined by HEW official releases shortly following the passage of Title XIX. *See,* HEW informational release, October 1966, pp. 34a-39a *infra:* "There will be State-to-State differences in the amount, duration and scope of medical care and services," p. 38a; "Differences among States in adequacy of financial assistance, medical assistance, and social services have characterized the grant-in-aid programs from the beginning." *Id.* In 1966 the Secretary published the "Handbook of Public Assistance Administration, Supplement D, Medical Assistance Program" reproduced in part, pp. 40a-50a, *infra*. Nowhere in Supplement D provisions discussing "amount, duration and

scope" of services can any indication be found that HEW believed that Congress intended participating states to fund each and every conceivable "medically necessary" procedure falling within the five mandatory service categories, or, intended to limit the reach of the "reasonable standards" principle set forth in § 1396a(a)(17) to the optional categories of care.

Congressional amendments to Title XIX since its passage also undermine the inferences of intendment recently gleaned by the Secretary to the effect that states must fund all "medically necessary services" falling within the five mandate service categories. Thus, in 1968 Congress expanded § 1396d(a)(4) by adding clause B to provide for "early and periodic screening and diagnostic" services for minors. Act of Jan. 2, 1968, Pub. L. 90-248, § 302(a), 81 Stat. 905. Again in 1972, § 1396d(a)(4) was expanded by Congress to require the provision of "family planning services." Act of Oct. 30, 1972, Pub. L. 92-603, § 299E(b), 86 Stat. 1384. Neither of the services added by Congress to 1396d(a)(4) can fairly be characterized as "medically necessary." These congressional actions do not permit any inference, as suggested by the Secretary, that the five mandated service categories are the repository of all "medically necessary" care, while the optional service categories encompass "medically unnecessary" or elective care.

Moreover, Director Miller submits that the fatal flaw in the Secretary's interpretation is her failure to give *any* significance to congressional repeal in 1972 of the comprehensive program requirement, Section 1903(e) of the Act [42 U.S.C. § 1396b(e)]. Pub. L. 92-603, § 203. As interpreted by her predecessors, § 1396b(e) was intended by Congress to effect a "broadening of scope of services made available," p. 41a, *infra,* and "progressive improvement in breadth and depth of the medical assistance program, quality of care, and adequacy of administration." *Id.*

The repeal of § 1396b(e) by Congress removed any notion that states were to achieve comprehensive care. There is no evidence that Congress intended to retain a residual "comprehensiveness" requirement limited in scope to the five mandatory categories of services. Therefore, the appropriate inference to be drawn from the available legislative history is that Congress was content with the original limitation it imposed upon states participating in Title XIX, *i.e.,* to employ "reasonable standards . . . for determining eligibility for and the extent of medical assistance . . . consistent with the objectives of" the Act. 42 U.S.C. § 1396a(a)(17).

Illinois urges the Court to reject the Secretary's statements concerning Title XIX's requirements as contained in footnote 23 of the Brief for the United States and as explicated in the Supplemental Brief filed in *Rush* v. *Poythress.* These statements, erroneous as a matter of law, are at odds with Congressional amendments to Title XIX, HEW's original understanding of and established practice under the Act, and therefore deserve none of the respect or deference this Court is inclined to extend the longstanding, consistent views of administrative agencies charged with the enforcement of complicated statutory schemes.[6]

Rather, the Court should conclude that Congress, without regard to the Hyde Amendment, did not intend to compel the states to fund all medically necessary procedures or all medically necessary abortions as a condition of participation and receipt of federal funds under Title XIX. The standard for

[6] If, however, the Court were to defer to the Secretary on the representations in footnote 23, insofar as these statements accurately represent the policy and practice of the agency, then the Court is urged to find this policy and practice to be *ultre vires* as measured by § 1396a(a)(17), or alternatively, to be without any legal force and effect for failure of the Secretary to comply with the rulemaking provisions of 5 U.S.C. § 553.

measuring a state plan limitation on medical care and services was and remains the "reasonable standards" concept in § 1396a(a)(17). That standard is satisfied here where Illinois with due regard for its interest in fetal life funds "life-preserving" abortions and alternative modes of treatment for the complications of pregnancy in the absence of any "reasonable probability that the co-existence of pregnancy [and some other health problem] will materially and significantly shorten the mother's life-span." B. NATHANSON, ABORTING AMERICA 244 (1979), addendum, p. 81a, Brief of Appellant Miller.

III.

CONGRESSIONAL ENACTMENT OF PROFESSIONAL STANDARDS REVIEW LAWS DOES NOT SUPPLANT STATE DISCRETION TO MAKE THRESHOLD DETERMINATIONS OF COVERAGE UNDER TITLE XIX.

The position of the Plaintiffs is that even if the provisions of 42 U.S.C. § 1396 *et seq.* do not mandate compulsory state funding of all "medically necessary" procedures,[7] such a requirement may be found in Congress' establishment of Professional Standards Review Organizations (PSROs). Brief for Appellees, pp. 80-85. Plaintiffs submit that the sole intent of

[7] Although the United States, in its brief, has interpreted the Social Security Act to require states to fund all "medically necessary" procedures, HEW has placed no reliance on the PSRO legislation. *See* Brief for the United States, pp. 45-49. The expertise of the federal agency charged with the administration of the welfare program that the PSRO provisions do not require the funding of all medically necessary procedures is entitled, at least in this context, to some weight. *Cf. Quern* v. *Mandley,* 436 U.S. 725, 743-44 n. 19 (1977); *New York Dept. of Social Services* v. *Dublino,* 413 U.S. 405, 421 (1973); *Udall* v. *Tallman,* 380, U.S. 1, 16 (1965).

Congress in providing for the establishment of PSROs was to ensure that "provision of health care and . . . payment for such services will be made—(1) only when, and to the extent, *medically necessary,* . . ." 42 U.S.C. § 1320c (emphasis added). Defendant Miller contends, however, that Plaintiffs, by narrowly focusing on such language have totally misconstrued Congress' intent in enacting this legislation and the role that PSROs were to play in effectuating this intent. Statutory interpretation requires not merely looking to the language of a particular clause; rather, this Court should view this section in light of the whole statute, *Kokoszka* v. *Belford,* 417 U.S. 642, 650 (1974). All parts of a law should be considered and construed together. *Boys Markets, Inc.* v. *Retail Clerks' Union, Local 770,* 398 U.S. 235, 250(1970). The express language of 42 U.S.C. § 1320c *et seq.* (1976), *as amended by* Act of Oct. 25, 1977, Pub.L.No. 95-142, 91 Stat. 1176 and the relevant legislative history establish that Congress intended to curb the untoward effect that overutilization of medical services was having on health care and its concomitant economic impact on state and federal welfare budgets. Moreover, the proper function of PSROs, within this statutory framework, is to *review* the appropriateness and quality of hospital services provided under the state Medicaid programs; the PSRO legislation in no way purports to modify a State's discretion to *initially* determine those medical services that are covered by a state's Medicaid program.

In examining the tremendous rising costs in implementing the Medicare and Medicaid programs, the Senate Committee on Finance noted:

> The Committee on Finance has, for several years, focused its attention on methods of assuring proper utilization of these services. That utilization controls are particularly important was extensively revealed in hearings conducted by the subcommittee on Medicare and Medicaid. Witnesses testified that a significant proportion of the health services provided under Medicare and Medicaid are prob-

> ably not medically necessary. In view of the per diem costs of hospital and nursing facility care, and the costs of medical and surgical procedures, the economic impact of this overutilization becomes extremely significant. Aside from the economic impact the committee is most concerned about the effect of overutilization on the health of the aged and poor. Unnecessary hospitalization and unnecessary surgery are not consistent. S.REP.NO. 92-1230, 92nd Cong., 2d Sess. 254(1972).

This problem of overutilization led Congress to enact Section 249F of Title II of the 1972 Amendments to the Social Security Act, 42 U.S.C. §§ 1320c-1320c-19, entitled "Professional Standards Review." The Congressional intent behind enactment of this legislation is set forth in Section 1320, which provides that in "order to promote the effective, efficient, and economical delivery of health care services of proper quality" and in light of "the interests of patients, the public, practitioners, and providers in improved health care services, it is the purpose of this part to assure, through the application of suitable *procedures of professional standards review,"* that payment for services performed under Medicare and Medicaid will be made:

> (1) only when, and to the extent, medically necessary, as determined in the exercise of reasonable limits of professional discretion; and
>
> (2) in the case of services provided by a hospital or other health care facility on an inpatient basis, only when and for such period as such services cannot, consistent with professionally recognized health care standards, effectively be provided on an outpatient basis or more economically in an inpatient health care facility of a different type, as determined in the exercise of reasonable limits of professional discretion. 42 U.S.C. § 1320c (emphasis added).

The actual responsibilities of the PSRO are set forth in 42 U.S.C. § 1320c-4 and its implementing regulations, 42 C.F.R. § 460 *et seq.*

The statutory responsibility and function of each PSRO is "to assume responsibility for the *review* of the professional activities" of providers "in the provision of health care services and items *for which payment may be made."* 42 U.S.C. § 1320c-4(a)(1)(1977) (emphasis added).

The clear import of this provision is that PSROs are "to assume responsibility for comprehensive and ongoing *review of services covered* under the Medicare and Medicaid programs." H.R. REP.NO. 231, 92nd Cong., 2d Sess. 1 (1971), *reprinted in* [1972] U.S. CODE CONG. & AD. NEWS, 4989, 5391-92 (emphasis added). The 1977 amendments to the PSRO provisions, Act of Oct. 25, 1977, Pub.L.95-142, 91 Stat. 1183, establish Congress' intent that PSRO legislation "would not effect other provisions of existing law relating to determinations with respect to conditions for eligibility to or payments of benefits." H.R.REP. NO. 393, 95th Cong. 1st Sess. 1, 55, *reprinted in* [1977] U.S. CODE CONG. & AD. NEWS, 3039, 3058. PSROs have absolutely no jurisdiction over issues of coverage or scope of benefits. *See* 42 C.F.R. § 463.18 (1979).

42 C.F.R. § 463.27(c)(3) provides that "PSRO determinations shall not preclude appropriate coverage determinations under the provisions of Title XIX of the Act with regard to issues that are not subject to PSRO determination." The regulations promulgated by HEW go on to explain that:

> [s]ections 463.26(c) and 463.267(c) make clear that the Department under Title XVIII and the States under Title XIX may establish *the services that are covered on a uniform basis (scope of benefits).* However, to the extent *individual* medical judgments are required to *implement these coverage rules,* it is the PSRO's responsibility and authority to make these medical judgments which must be followed by the Medicare fiscal agents and State Medicaid agencies.

43 Fed.Reg. 7406 (Feb. 22, 1978) (emphasis added). Plaintiffs, however, place much reliance on the fact that the 1972 PSRO statute requires that PSROs develop appropriate "norms of care, diagnosis, and treatment based upon typical patterns of practice in its region (including typical lengths-of-stay for institutional care by age and diagnosis) as principal points of evaluation and review." 42 U.S.C. § 1320c-5(a) (1976). Brief for Appellees, pp.83-84. Plaintiffs go on to point out that in 1977 Congress amended the PSRO provisions to avoid "disruptive duplicative reviews." H.R.REP. NO. 393(I), 95th Cong., 1st Sess.54, *reprinted in* [1977] U.S. CODE CONG. & AD NEWS, 3039, 3056. Finally, plaintiffs, relying on language from 42 U.S.C. § 1320c-7(c) (1976), *as amended by* Act of Oct. 25, 1977, Pub.L. 95-142, 91 Stat. 1185 boldly state that "[a] PRSO review is 'the conclusive determination on' issues of medical necessity 'for purposes of payment under this chapter, and no reviews with respect to those determinations shall be conducted . . . [by] state [Medicaid] agencies.'" Brief for Appellees, pp. 84-85. Plaintiffs' reliance on § 1320c-7(c), however, is without basis. As a preliminary matter, PSRO review is conclusive with respect to determinations made pursuant to 42 U.S.C. § 1320c-4(a)(1) 4(a)(1) & (2). Defendant Miller has established, and plaintiffs have refused to recognize that § 1320c-4(a)(1) provides for PSROs assuming the responsibility for *reviewing* professional activities within their respective areas; this section in no way affects the State's discretion to initially determine what services are covered by a State's Medicaid plan. Moreover, such PSRO determinations are subject to the provisions of 42 U.S.C. §§ 1320c-8 & 1320c-20(a)(1), (d)(3). Section 1320c-8 provides for administrative review whenever a beneficiary, recipient of benefits, provider or practitioner is "dissatisfied with a determination with respect to a claim made by a [PSRO] in carrying out its responsibilities for the review of professional activities in accordance with paragraphs (1) and (2) of § 1320c-4(a) . . . ." Far from substantiating the wide

physician discretion, urged upon this Court by plaintiffs, to initially determine which services are covered, this section makes clear the fact that the PSRO's function is to undertake the case by case review of individual requests for reimbursements, subject to administrative review, and to ensure that no treatment which is not medically necessary is reimbursed.

The restriction of Section 1320c-20(a)(1) provides that a PSRO determination is not conclusive "unless such organization has entered into a memorandum of understanding, . . . , with the single State agency responsible for administering [the State Medicaid plan]". The objective of such a memorandum is to facilitate efficient utilization review and remove any overlap between the PSRO and the State agency; the memorandum "delineat[es] the relationship between the [PSRO] and the State agency' as well as providing for the exchange of data or information, administrative procedures, and coordination mechanisms. Section 1320c-20(d)(3) provides for State agency challenge to PSRO review determinations when the agency presents reasonable documentation; if HEW determines that the PSRO's review determinations have "caused an unreasonable and detrimental impact on total State [Medicaid] expenditures . . . and the appropriateness of care received by [Medicaid recipients]," then, unless HEW finds that the PSRO has taken appropriate corrective action, it *must* suspend the PSRO's authority to make conclusive review determinations. The clear import of these limitations is that Congress did not intend to vest physicians in PSROs with the wide discretion to initially determine what services are "medically necessary." Rather, Congress' objective was to curtail the unchecked exercise of physician discretion in order to promote the underlying policies of efficient utilization review and proper health care services for Medicaid recipients. As HEW has stated, "[i]t was because the Medicare fiscal agents and State Medicaid agencies were determined not to be performing effective utilization review by Congress that the Congress instituted the PSRO concept . . ." 43 Fed.Reg. 7406 (Feb. 22, 1978).

IV.

THE "MEDICALLY NECESSARY" ABORTION SERVICES WHICH PLAINTIFFS SEEK ARE ESSENTIALLY "PREVENTIVE" SERVICES WHICH ILLINOIS MAY FREELY EXCLUDE UNDER TITLE XIX.

Oren Richard Depp, III, M.D. has stated that in his opinion the medical treatment which indigent women "need" short of circumstances covered by the Illinois statute is treatment that "seeks to avoid risks to 'health,' " Depp. affidavit, Joint Appendix, p.104. Dr. Depp explains the basis for this perceived "need" as follows: "[T]he vast majority of medical problems associated with pregnancy appear during the early stages of pregnancy as uncertain health risks and do not reach the level of life-threatening or severe and long lasting health problems until later." Depp. affidavit, Joint Appendix, p. 105. Thus abortions are "necessary" to prevent future health problems and to avoid risks to health and not to *treat* the "vast majority of medical problems" which may co-exist with pregnancy during the first trimester. Defendant submits that this characterization of the types of abortions for which plaintiffs seek funding defines those services as "preventive" treatment.

"Preventive" care under Title XIX is not the same as medically unnecessary care or elective treatment. The Secretary of Health, Education and Welfare in a rule promulgated in the Code of Federal Regulations has defined "Preventive services" as follows:

> [S]ervices provided by a physician .... to—
>
> (1) Prevent disease, disability, and other health conditions or their progression;
>
> (2) Prolong life; and
>
> (3) Promote physical and mental health and efficiency.

42 C.F.R. § 440.130(c).

It follows therefore that the "vast majority" of the abortions which plaintiffs characterize as "medically necessary" are in fact properly characterized as a "preventive service" designed to "prevent disease, disability .... or their progression." This is especially true of those abortions claimed to be necessary for "mental health" reasons.

There is no statutory mandate under Title XIX by which Illinois is compelled to fund "preventive services," conceded by all parties to this appeal to fall within the optional categories of service. 42 U.S.C. § 1396d(a)(6)-(17). Accordingly, Illinois is free to exclude so-called "medically necessary" abortions which are essentially preventive in nature, and may validly elect to limit abortion funding to circumstances necessary for the preservation of life as that standard has been interpreted in Appellant Miller's Brief, p. 43-44: "There must ... be a reasonable probability that the coexistence of pregnancy [and diseases complicating pregnancy] will materially and significantly shorten the mother's life" or that "pregnancy raises the risk of imminent death," quoting from B. NATHANSON, ABORTING AMERICA 244 (1979).

V.

P.A. 80-1091 IS A RATIONAL MEANS TO PURSUE THE STATE'S LEGITIMATE INTEREST IN FETAL LIFE.

Plaintiffs argue that Illinois' adoption of a "life preservation" standard for the funding of public assistance abortions demonstrates "Illinois' reckless unconcern with actual maternal life and health and is an irrational way to serve any legitimate interest" in fetal life. Brief of Appellees, p. 40. Disclaiming any "fundamental right to a publicly funded abortion", Brief of Appellees, p. 42, plaintiffs urge affirmance of the District Court's decision based upon Illinois' alleged discrimination against the "fundamental right ... in making the abortion decision" by denying funds for a particular medical procedure

within an otherwise comprehensive medical assistance program covering "all medically necessary care". Brief of Appellees, pp. 42-43.

However, as Illinois does not have a comprehensive Title XIX program and does not purport to cover "all medically necessary care", plaintiffs argument is inapposite and the scope of Illinois' program does not define the discrimination, if any, here.

Due to Illinois' willingness to fund alternative modes of care and treatment for the complications of pregnancy, the Court should be hesitant to accept plaintiffs' contention that Illinois has erected a "direct purposeful barrier" to medical care *per se* and thereby has "penalized" the decision to abort. See, Brief of Appellees, pp. 46-47, relying on the decision in *Memorial Hospital* v. *Maricopa County,* 415 U.S. 250 (1974).

Plaintiffs purport to find support for application of the "penalty" analysis by reference to the "Illinois legislature's *precise* purpose . . . to prevent as many women as possible from exercising" their right to decide to abort. Brief of Appellees, p. 48. Defendant concedes that any regulatory or appropriation measure, be it federal or state in origin, may affect the behavior of those regulated and who receive public funds. This concession, however, does not establish that plaintiffs or the Court may divine in P.A. 80-1091 a "precise purpose" to penalize the exercise of a right unless such purpose be found either expressly in, or by necessary implication from the words of the statute itself. To the extent that plaintiffs' argument here may concern legislative *motivation,* this Court has often stated that the legislators' state of mind is irrelevant and that constitutionality of legislation should be determined solely by a law's effects. *United States* v. *O'Brien,* 391 U.S. 367 (1968); *Palmer* v. *Thompson,* 403 U.S. 217 (1971); *cf., Washington* v. *Davis,* 426 U.S. 229 (1976); *Village of Arlington Heights* v. *Metropolitan Housing Development Corp.,* 429 U.S. 252 (1976).

The debates surrounding P.A. 80-1091, Joint Appendix, pp. 42-88, do not show that the legislators who voted for the bill were single-mindedly motivated by a desire to "penalize" welfare mothers or to work a discriminatory denial of medical care. The debates addressed a wide variety of factors and considerations, foremost of which were the desire to promote fetal life and to respect the moral beliefs of the legislators' constituents that public funds should not be used to finance any abortion unless necessary to preserve the woman's life. Supporters of P.A. 80-1091 countered suggestions of discrimination by noting that "the state currently makes no pretense of paying for any and all medical procedures." Representative Leinenweber, Joint Appendix, p. 43.

There is not a single documentation of fact in the record below as to the discriminatory *impact* of P.A. 80-1091 since its enactment on indigent pregnant women in Illinois apart from the speculations and fears to be found in the affidavits of plaintiffs-affiants. If actual incidents of maternal health impairment are documented in the future, it would remain to be demonstrated that *but for* P.A. 80-1091 no such health impairment would have occurred. And even were some causal connection established between the enforcement of the law and an actual increase in "maternal morbidity and mortality", *Zbaraz* v. *Quern,* 469 F.Supp. 1212, 1220 (N.D. Ill. 1979), the determination of the rationality of P.A. 80-1091 as a means of promoting the state's interest in fetal life would turn, in part, upon the empirical measurement of any such impact, and especially upon whether health impairment was short or long term. As this Court recently observed in a different context:

> The process of making the determination of rationality is, by its nature, highly empirical, and in matters not within specialized judicial competence or completely commonplace, significant weight should be accorded the capacity of Congress to amass the stuff of actual experience and cull conclusions from it. *United States* v. *Gainey,* 380 U.S. 63, 67, 85 S.Ct. 754, 757, 13 L.Ed.2d 658 (1965).

Usery v. *Turner Elkhorn Mining Co.*, 428 U.S. 1, 28 (1977) (Judicial deferral to legislative presumptions regarding disability and entitlement to benefits under the Coal Mine Health and Safety Act of 1969).

Charges by plaintiffs that the legislative action on review is irrational or that the state has abandoned any "neutral stance" by refusing to fund all "medically necessary" abortions are wide of the mark. Given the wide spectrum of informed opinion which reasonable men and women hold on the controversial and unsettled questions of abortion morality, limited state financing of abortions may well be the most "neutral stance" a state can take while dispassionate scientists, shunning simplistic slogans and ideological manipulations of fact, seek further answers to the questions posed:

> The key practical question [in the abortion debates] is to determine when a fetus becomes human. . . . This essential human quality, I believe, can only be our intelligence. . . . The particular sanctity of human life can only be identified with the development and functioning of the neocortex. We cannot require its full development because that does not occur until many years after birth. But perhaps we might set the transition to humanity at the time when neocortical activity begins, as determined by electroencephalography of the fetus.

C. SAGAN, DRAGONS OF EDEN—SPECULATIONS ON THE EVOLUTION OF HUMAN INTELLIGENCE, 208 (1977)

It is the *raison d'etre* of the state to preserve and promote the sanctity of human life. While our scientists are searching for and finding new answers to fetal development and our perinatal physicians are relentlessly pressing back to an earlier point in time of fetal development the point at which a fetus can, with technological life support systems, sustain life outside of the womb, the rationality of state action in this area might well be judged by how efficacious are the efforts of the state to preserve and promote the health, life and well-being of *both* the

mother and the fetus in a *mutually interdependent fashion.* State retention of fiscal autonomy to limit abortion funding by a medically sophisticated "life preservation" standard while simultaneously providing funds for childbirth and alternative modes of treatment for the health problems of the pregnant mother fosters this approach.

By adopting such an approach the legislature does not, "by adopting one theory of life, . . . overide the rights of the pregnant woman that are at stake." *Roe* v. *Wade,* 410 U.S. 113, 162 (1973). The right to decide to abort under P.A. 80-1091 is preserved here and is as free from active state interference as it was in *Maher* v. *Roe,* 432 U.S. 464 (1977). Thus, despite plaintiffs' insinuations of base legislative motive and invidious discrimination, the Court should not be quick to distrust on equal protection grounds a state's fiscal policy encouraging childbirth formulated by elected representatives of the people which "places no obstacles-absolute or otherwise—in the pregnant woman's path to a [medically necessary] abortion." 432 U.S., at 474.

CONCLUSION

Defendant-Appellant Miller prays this Court to reverse the decision of the District Court holding the Hyde Amendment and Illinois P.A. 80-1091 unconstitutional, and to reverse, in part, the decision of the Circuit Court of Appeals holding that, without regard to the Hyde Amendment, Title XIX forbids Illinois to limit its funding of abortions to those necessary for the preservation of the life of the pregnant woman.

Respectfully submitted,

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APPENDIX

No. 77-2743

IN THE

UNITED STATES COURT OF APPEALS

FOR THE FIFTH CIRCUIT

CAROLYN RUSH (Pseudonym)

Plaintiff-Appellee,

vs.

DAVID POYTHRESS, Commissioner, Georgia Department of Medical Assistance and JOSEPH A. CALIFANO, Jr., Secretary, Department of Health, Education, and Welfare,

Defendants-Appellants.

On Appeal From
The United States District
Court for the
Northern District
of Georgia

BRIEF FOR THE FEDERAL APPELLANTS

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STATEMENT OF THE CASE

Course of Proceedings and Disposition in Court Below

The Secretary adopts by reference the State appellant's statement of the course of proceedings and disposition in the Court below at pages 2-7 of the State's previously filed brief.

Statement of Facts

This was an action for declaratory, injunctive and mandamus relief against state and federal officials seeking financial reimbursement under Title XIX of the Social Security Act, 42 U.S.C. § 1396, *et seq.* (1970) (hereinafter "Medicaid") for a particular type of surgery generally referred to as sex reassignment or transsexual surgery. Payment for this medical service has been denied by the state defendants pursuant to a State Medicaid Plan, approved by the Department of Health, Education, and Welfare (hereinafter "the Secretary"), which prohibited reimbursement for "transsexual operations." Plaintiff alleged that the denial of payment for this service violated her rights[1] under the Equal Protection Clause of the Fourteenth Amendment and 42 U.S.C. §§ 1396d(a)(1) and (5) which require that state plans provide inpatient hospital services and physicians' services to the categorically needy.[2] Based on these allegations, plaintiff petitioned the District Court to enjoin application of the challenged state plan provisions and order reimbursement for her transsexual surgery. With respect to the Secretary, plaintiff sought a mandamus requiring him to disapprove Georgia's existing state plan for Medicaid.

Upon cross motions for summary judgment, the District Court granted judgment in favor of plaintiff. Specifically, the District Court held that:

> "[T]he Georgia State Medicaid Plan and its attendant regulations insofar as they irrebuttably deny Medicaid benefits for transsexual surgery, which involves procedures within the five required categories of 42 U.S.C. §§ 1396(a)(13)(B), 1396d(a)(1)-(5) are DECLARED

[1] Plaintiff, although anatomically male, has stated in briefs that she prefers use of the feminine pronoun.

[2] The categorically needy include needy families with dependent children, the aged, the blind, and disabled. 42 U.S.C. § 1396a(a)(1)(A).

> invalid as a violation of plaintiff's federally afforded rights. The State Defendant: (1) is ENJOINED from application of the State Medicaid Plan and regulations insofar as they irrebuttably deny Medicaid benefits for transsexual surgery and (2) is ORDERED to approve plaintiff's petition for Medicaid reimbursement of the inpatient hospital and physicians' services related to the proposed surgery. The Federal defendant is ORDERED to disapprove the Georgia State Plan and its attendant regulations insofar as they irrebuttably deny Medicaid coverage for transsexual surgery involving services or procedures within the five required categories of 42 U.S.C. §§ 1396(a)(13)(B) and 1396d(a)(1)-(5)."

The Court based its holding on two major findings: (1) that "Medicaid coverage [for services set forth in 42 U.S.C. § 1396d(a)(1)-(5)] is not optional or discretionary for necessary medical treatment of eligible recipients" (Record, p. 463) and (2) that "the attending physician's judgment concerning appropriate treatment where medically necessary must suffer no interference." (Record, p. 464). Taken together these findings mean that no physicians' or inpatient hospital services can be excluded from a state plan, or, conversely, that the state must provide payment for any and all such services when they are deemed necessary by the attending physician. It is this order, and more particularly the premises on which it is based, which the Secretary submits are in error. A stay of the order pending appeal was granted by this Court on September 28, 1977.

Nature of The Medicaid Program

The operation of Medicaid is governed by Title XIX of the Social Security Act and by regulations promulgated thereunder. Title XIX established a cooperative federal-state program "[f]or the purpose of enabling each state, as far as practicable under the conditions in each state, to furnish medical assistance" to certain needy individuals "whose income and re-

sources are insufficient to meet the costs of necessary medical services." 42 U.S.C. § 1396; *Opelika Nursing Home, Inc.* v. *Richardson,* 448 F.2d 658 (5th Cir. 1971). States are not required to institute a Medicaid program, but if they choose to do so, they must submit to the Secretary of Health, Education, and Welfare a satisfactory "state plan" which fulfills all requirements of the Act. *See* 42 U.S.C. § 1396a. Included among those requirements which a state must meet in order to obtain plan approval and continued federal funding is the condition set forth in 42 U.S.C. § 1396a(a)(13)(B) that states must provide to the categorically needy, those services set forth in 42 U.S.C. § 1396d(a)(1)-(5). The five general categories of medical services which must be included in the state plan are: (1) inpatient hospital services; (2) outpatient hospital services; (3) other laboratory and X-ray services; (4) skilled nursing facility, periodic screening and diagnosis of children, and family planning services; and (5) physicians' services. 42 U.S.C. §§ 1396a(a)(13)(B) and 1396d(a)(1)-(5).[3]

The state plan describes the nature and scope of the state's Medicaid program and provides assurances that the state will administer its program in conformity with the requirements of the federal statute, regulations and other applicable official issuances of the Department. 45 C.F.R. § 201.2. If the state submits a plan which fulfills all the requirements of the Act, the Secretary must approve it. 42 U.S.C. § 1396a(b); *Johnson's Professional Nursing Home* v. *Weinberger,* 490 F.2d 841 (5th Cir. 1974). The state thereupon becomes entitled to grants of federal funds in reimbursement of a portion of the expenditures which it makes in providing specific types of medical assistance to eligible individuals under the plan in accordance with federal conditions. 42 U.S.C. § 1396b; 45 C.F.R. § 201.5. Georgia

[3] Although the states need not extend Medicaid coverage beyond the five basic classes of services, Georgia has chosen to provide coverage for additional medical services for the categorically needy.

participates in the Medicaid program under an approved state plan.

The Medicaid programs are administered by the states and not the federal government. *See Johnson's Professional Nursing Home* v. *Weinberger, supra.* While a number of federal legal and policy provisions affect state action under the program, it is the states which have responsibility, *inter alia,* for establishing the level of reimbursement for providers of services under Medicaid, determining the conditions of provider participation in the program, entering into provider agreements establishing the scope of services to be offered under the particular state's program, determining the level of state appropriations for the program and affording fair hearings. *See generally* 42 U.S.C. § 1396a. The Secretary may perform none of these functions.

Once the state plan is approved, the Secretary's function is largely limited to making payments to the state for appropriate expenditures under the plan. The Secretary also maintains general oversight of the state's program to ascertain whether the state is fulfilling its plan commitments. Should the state's compliance with federal requirements come into question, the Secretary attempts to resolve such problems by consultation and negotiation with the state. *See generally* 45 C.F.R. § 201. If the state fails to correct the deficiency and the Secretary determines that the deficiency constitutes a failure "to comply substantially" with federal requirements, the statute requires the Secretary to terminate all or part of the state's title XIX funds, but only after notice to the state and opportunity for hearing. 42 U.S.C. § 1396c; 45 C.F.R. §§ 201, 213.

SUMMARY OF THE ARGUMENT

A state is not required to provide payment under its Medicaid program for every medical service which the treating physician determines to be medically necessary. Instead, a state may use reasonable standards in determining the extent of medical assistance to be covered. A fair reading of Title XIX demonstrates that the application of this reasonable standards test is not limited to the decision by a state whether to reimburse the "optional" services. 42 U.S.C. §§ 1396d(a)(6)-(17). Instead, this test also guides a state in its determination of whether to exclude certain inpatient hospital or physicians' services. 42 U.S.C. § 1396d(a)(1) and (5).

Furthermore, the District Court erred in holding that the attending physician's professional judgment concerning medical necessity must suffer no interference. The Medicaid statute in fact mandates review of the attending physician's judgment in a number of areas.

ARGUMENT

I.

THE LANGUAGE AND LEGISLATIVE INTENT OF TITLE XIX SUPPORT THE POSITION THAT THE STATES ARE REQUIRED ONLY TO UTILIZE REASONABLE STANDARDS AND ARE NOT COMPELLED TO PAY FOR ALL INPATIENT HOSPITAL AND PHYSICIANS' SERVICES.

It is the Secretary's position on appeal that a state may employ reasonable standards in determining the extent of medical assistance to be covered under Medicaid and that the lower court erred in holding that a state is compelled to include in its coverage every medical procedure, within the categories provided in 42 U.S.C. § 1396d(a)(1)-(5), which a physician determines to be medically necessary. *See Virginia Hospital Association* v. *Kenley,* 427 F.Supp. 781 (E.D. Va. 1977).

Indeed, it is important to note that the sole Congressionally imposed requirement which deals directly with the extent of medical assistance to be provided under Medicaid is that a state include reasonable standards which are consistent with the objectives of the Act. 42 U.S.C. § 1396a(a)(17). That section of the statute provides that:

> "A State plan for medical assistance must . . . include reasonable standards . . . for determining eligibility for and the extent of medical assistance under the plan which . . . are consistent with the objectives of this [Title]."

The Supreme Court, in *Beal* v. *Doe,* ____ U.S. ____, 97 S.Ct 2366 (1977) affirmed that the states, in fashioning the coverage of their Medicaid programs, are required only to employ reasonable standards. Citing § 1396a(a)(17), the Court noted:

> . . . the statute is cast in terms that require participating States to provide financial assistance with respect to five

> broad categories of medical treatments. *But nothing in the statute suggests that participating States are required to fund every medical procedure that falls within the delineated categories of medical care.* Indeed, the statute expressly provides that:
>
> > "A State plan for medical assistance must . . . include reasonable standards . . . for determining eligibility for and the extent of medical assistance under the plan which . . . are consistent with the objectives of this [Title] . . ." 42 U.S.C. § 1396(a)(17).
>
> This language confers broad discretion on the States to adopt standards for determining the extent of medical assistance, *requiring only that such standards be "reasonable"* and "consistent with the objectives" of the Act. *Doe* v. *Beal,* ____ U.S. ____ 97 S.Ct. at 2370-71. (emphasis added)

It is by this reasonable standards test that the District Court should have judged the Georgia State Medicaid Plan.

There is no legislative history to indicate precisely what Congress meant when it said that the state plan must include "reasonable standards . . . for determining the extent of medical assistance." However, reasonable interpretation of that phrase and an analysis of Title XIX indicate that Congress intended that the states would have the power to exclude from coverage some services and forms of treatment which might be determined by some physicians to be medically necessary and that the District Court erred in limiting the application of that test to optional services § 1396d(a)(6)-(17), and medically unnecessary services.

The District Court's interpretation of 42 U.S.C. § 1396a(a)(17) is inconsistent with the import of Title XIX. Congress specifically enabled states to categorically exclude from Medicaid coverage those types of medical services listed in 42 U.S.C. § 1396d(a)(6)-(17), the so-called optional services. 42 U.S.C. § 1396a(a)(13)(B) and (C)(i). Thus, any inter-

pretation of § 1396a(a)(17) to mean that the "reasonable standards" language was intended to guide the state's decision as to whether the optional services should also be covered becomes superfluous. Such an interpretation would strain all principles of statutory construction since the states are allowed to exclude these services without justification and even in the face of reason. Nor is there any indication that Congress intended the States' discretion to be limited to what would, in most cases, be a relatively small number of not medically necessary services they might choose to provide.

The discretion afforded the states under the reasonable standards test is not unlimited. The Secretary has provided by regulation that the medical services covered "... must be sufficient in amount, duration and scope to reasonably achieve their purpose." 45 C.F.R. § 249.10(a)(5)(i). The states "may not arbitrarily deny or reduce the amount, duration, or scope of, such services ... solely because of the diagnosis, type of illness or condition." *Id.*[4] This regulation is consistent with the statutory intent of allowing states to determine the amount of medical assistance to be provided by a reasonableness stan-

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[4] In a recent case brought to the attention of the Court *Doe* v. *Minnesota Department of Public Welfare,* 46 U.S.L.W. 2160 (August 19, 1977), the Minnesota Supreme Court held that the state's exclusion of transexual surgery from its state plan violated this regulation. That Court did not find that 42 U.S.C. §§ 1396d(a)(1) and (5) required the state Medicaid plan to include every inpatient hospital or physicians' service which a treating physician deemed medically necessary. Rather the only federal violation found by the Court was denial of services on the basis of type of illness or condition. The Court noted that evidence presented by plaintiff that surgery was the only effective therapy for transsexualism had been uncontested. In the instant case, however, the Secretary has submitted evidence to show that psychotherapy is an effective form of treatment, thus placing in issue plaintiff's assertion that Georgia's refusal to reimburse the cost of surgery is tantamount to discrimination on the basis of type of illness.

dard. Great deference should be given to the Secretary's interpretation of the statute. *Beal* v. *Doe, supra,* at p. 2372; *New York Department of Social Services* v. *Dublino,* 413 U.S. 405 (1973). This is particularly true where the Secretary's interpretation is consistent with the statutory objective of enabling "each State, *as far as practicable* under the conditions in the State" to furnish medical assistance to the needy. 42 U.S.C. § 1396. (emphasis added).

As has been previously demonstrated, the United States Supreme Court, in *Beal* v. *Doe,* has unequivocally stated that Title XIX grants the states broad discretion to adopt standards for determining the extent of medical assistance, with the only provision being that such standards be reasonable and consistent with the objective of the Act. It is the position of the Secretary that the Supreme Court's decision allows a state plan to exclude from coverage services which a physician may deem to be medically necessary for his patient, so long as the state's action has a reasonable basis and does not discriminate on the basis of diagnosis. 45 C.F.R. § 249.10(a)(5)(i). The District Court, however, while recognizing that a state has reasonable discretion within the five mandatory categories to formulate a state plan, held that, under *Beal,* such discretion does not extend to those services which are deemed medically necessary by a treating physician. In doing so the District Court relied upon the following language:

> "Although serious statutory questions might be presented if a state Medicaid plan excluded necessary medical treatment from its coverage, it is hardly inconsistent with the objectives of the Act for a State to refuse to fund *unnecessary*—though perhaps desirable—medical services," *Id.* at 2371. (emphasis in original). Record, p. 463.

This passage does not indicate that *all* medically necessary treatment must be covered by Medicaid. What the Court was saying was that, if such treatment were excluded from coverage, serious statutory questions would be raised since the state

would have a heavier burden of demonstrating compliance with the reasonable standards test since a service determined to be medically necessary had been excluded. The Secretary agrees that such questions are arguably raised in the case *sub judice*. It is for this reason that he submitted the affidavits of two psychiatrists experienced in the treatment of transsexuals who expressed the opinion that psychotherapy (available under the Georgia State Plan) was not only an alternative, but a preferable mode of treatment. That evidence was necessarily ignored by the District Court which elevated the opinion of the treating physician above that of the state or experts in the field. This, it is submitted, was not the intention of Congress or the meaning of the Supreme Court in *Beal*.

Rather than categorically prohibiting a state from refusing to reimburse the cost of any medically necessary procedure, the Supreme Court was indicating that it will demand that the state provide greater justification for the exclusion of such services. The State appellant should be given the opportunity on remand to provide such justification, and the Secretary the opportunity to show that, even measured against the heavier burden imposed by *Beal*, he did not abuse his discretion in approving the Georgia Plan.

II.

THE ATTENDING PHYSICIAN'S JUDGMENT OF MEDICAL NECESSITY IS NOT CONTROLLING ON THE ISSUE OF WHETHER THE STATE MUST PROVIDE PAYMENT FOR PARTICULAR INPATIENT HOSPITAL OR PHYSICIANS' SERVICES.

The Supreme Court in *Beal* v. *Doe* remanded for consideration by the District Court the issue whether Pennsylvania's practice of requiring concurrence by two physicians with the judgment of the attending physician that an abortion is medically necessary was in violation of Title XIX. In so doing, the

Court noted that the record was not complete enough to show "the precise role played by these two physicians, and ... whether this requirement interferes with the attending physician's medical judgment *in a manner not contemplated by the Congress.*" 97 S. Ct. at 2373. (emphasis added). While the Court expressed no opinion on the appropriate role of the attending physician under the statutory scheme, it is clear from the underlined language and from the fact that the remand was ordered, that the Court did not view the Medicaid Act as providing *carte blanche* to the physician for any and all services he might deem necessary.

But the District Court in the instant case held that "the attending physician's professional judgment concerning appropriate treatment where medically necessary must suffer no interference." (Record, p. 464). The Court was careful to limit its holding to state plan provisions which "irrebuttably [deny] coverage of any services or procedures within the five required categories" (*Id.*, p. 465), and denied any intention to interfere with the state's responsibility to conduct utilization review or control. (*Id.*, p. 469 at n. 13). Nevertheless, it is difficult to reconcile the District Court's view that the attending physician's opinion cannot be challenged for purposes of Medicaid reimbursement with a statutory scheme that mandates such processes as utilization review (42 U.S.C. § 1396a(a)(30)), review by Professional Standards Review Organizations (42 U.S.C. § 1320c *et seq.*), and "medical reviews" of nursing home patients (42 U.S.C. §§ 1396a(a)(20) and 1396a(a)(31)).[5]

For example, an attending physician might make a diagnosis of gastric ulcers and admit the patient for surgery.

---

[5] It should be noted that neither utilization review nor any other provision of the Medicaid Act precludes the physician from performing any service he deems necessary. These provisions are relevant only to the issue of whether the State and federal government will provide reimbursement for the procedure.

However, if his evaluation of his patient's condition was deemed unwarranted (*i.e.*, was not supported by adequate laboratory or clinical findings) the utilization review team would recommend discharge even though continued hospitalization would be justified were the attending physician's diagnosis correct. The recommendations of the utilization review process are not binding in the sense that discharge can be required; however, the State is not required to pay for treatment in the face of contrary utilization review findings.[6]

The Secretary recognizes that the above example may be distinguishable because no "irrebuttable presumption" is involved. Nevertheless, the opinion of the treating physician is ignored despite the fact that he believes hospitalization is medically necessary and all parties agree that, if his diagnosis is in fact accurate, hospitalization and surgery are necessary and appropriate.

Similar results will occur when professional standards review organizations become fully operational and take over the functions currently performed by utilization review. 42 U.S.C. § 1320c—4. Indeed, the PSRO legislation envisions that each PSRO will adopt certain standards and norms for treatment from which departures by the attending physician will have to be justified. 42 U.S.C. § 1320c—9. Likewise, medical review teams are required to visit nursing homes annually and review the record of each patient to determine whether appropriate treatment is being rendered and to determine whether the patient actually requires the level of care he is receiving. 42 U.S.C. § 1396a(a)(26) and 1396a(a)(31). Surely a statutory scheme which envisions these kinds of reviews of the attending physician's judgment in particular cases cannot be said to have foreclosed a judgment by the state that certain kinds of treatment will not be paid for, when other forms of treatment,

[6] Should the State determine not to make payment, the patient is entitled to a hearing pursuant to 45 C.F.R. § 205.10.

equally acceptable for all or most patients suffering from the condition, are covered under the plan. It is this kind of judgment which the State of Georgia has made and the Secretary approved. If it was wrong, this can be determined on remand when the District Court considers whether exclusion of transsexual surgery was in fact reasonable pursuant to the standards outlined in Section I of this Argument. It is respectfully submitted that neither Congress nor the Supreme Court intended to place the attending physician on the level prescribed by the District Court—subject to "no interference" or limitation.

CONCLUSION

On the basis of the foregoing, the Secretary respectfully urges that this Court reverse this order of the District Court, which granted summary judgment for plaintiff and denied summary judgment for the Secretary.

Respectfully submitted,

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United States Attorney

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UNITED STATES DEPARTMENT OF JUSTICE

WASHINGTON, D.C. 20530

Address Reply to the
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January 24, 1980

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137-79-433

Mr. Gilbert F. Ganucheau
Clerk, United States Court of Appeals
for the Fifth Circuit
Room 102, 600 Camp Street
U.S. Court of Appeals Courthouse
New Orleans, LA 70130

Re: *Carolyn Rush (Pseudonym)* v. *T. M. "Jim" Parham, etc., et al.; David Poythress, etc.; Joseph A. Califano, Jr., Secretary of Health, Education and Welfare* (C. A. 5, No. 77-2743)

Dear Mr. Ganucheau:

The above-captioned case was argued and submitted on September 24, 1979. The panel included Chief Judge Brown and Circuit Judges Tjoflat and Garza.

The Solicitor General has just filed a brief on behalf of the Department of Health, Education and Welfare which may affect the proper disposition of this appeal. *United States of America* v. *David Zbaraz*, No. 79-491 (Supreme Court). We are enclosing copies of that brief and ask that you distribute them to the members of the panel as soon as possible. We further ask that you direct their attention to the footnote which appears at pages 43 and 44 of that brief.

We will formally move for leave to file a supplemental memorandum which will explain the effect of the *Zbaraz* footnote upon the *Rush* appeal within approximately two weeks.

Very truly yours,

WILLIAM KANTER

William Kanter, *Assistant Director*
Appellate Staff

LINDA M. COLE

Linda M. Cole
Attorney, Appellate Staff

cc: See page 2.

The Department of Law
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132 STATE JUDICIAL BUILDING
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January 29, 1980

Mr. Gilbert F. Ganucheau, Clerk
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Fifth Circuit
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New Orleans, Louisiana 70130

RE: *Carolyn Rush* v. *T. M. "Jim" Parham, etc., et al.*
Civil Action No. 77-2743.

Dear Mr. Ganucheau:

We have received a copy of a letter from Ms. Linda M. Cole of the United States Department of Justice asking that you distribute copies of the federal brief in *United States of America* v. *David Zbaraz,* No. 79-491 (Supreme Court) to members of the panel in the above-captioned case, calling their attention to footnote 23 at pages 43 and 44 of that brief.

The State of Georgia strongly objects to this request. The submission of legal arguments without leave of court, albeit in a separate action, clearly violates the Federal Rules of Appellate Procedure and the local rules of the Fifth Circuit.

While we normally would not comment on substantive matters by letter, we find footnote 26 a blatant misstatement of fact. Federal defendants now seek at this late date to totally change their position as argued in their brief submitted Novem-

ber 30, 1977 and made at their oral argument on September 28, 1979. Federal rules do not permit such abuse of the appellate process.

The federal defendants have, until January 24, 1980, consistently maintained that "A state is *not* required to provide payment under its Medicaid program for every medical service which the treating physician determines to be medically necessary." [Emphasis added.] Federal Appellants' "Summary of Argument," p. 8. The federal appellants now seek to submit a new brief in which a footnote concludes: "[N]either the Medicaid Act nor the Secretary, however, has authorized participating states to eliminate coverage of a particular kind of medically necessary care."

The Justice Department does not argue intervening decisions or new developments. Rather it now seeks to reargue *Rush* from the beginning. The Justice Department has placed the State of Georgia in both an untenable and unfair position to which we strongly object.

We formally move that the brief submitted in *United States of America* v. *Zbaraz,* not be distributed to members of the panel and that the request to file a supplemental memorandum be denied.

Sincerely,

STEPHANIE B. MANIS

Stephanie B. Manis
Staff Assistant Attorney General

SBM/ad

cc: Chief Judge Brown
Judge Tjoflat
Judge Garza
Mr. William Kanter
Ms. Linda M. Cole
Mr. Kenneth Levin

IN THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

CAROLYN RUSH (pseudonym), ***Plaintiff-Appellee,*** **v.** **DAVID POYTHRESS, Commissioner, Georgia Department of Medical Assistance and PATRICIA R. HARRIS, Secretary of Health, Education and Welfare,** ***Defendants-Appellants.***	No. 77-2743

MOTION FOR LEAVE TO DEFER FILING A SUPPLEMENTAL BRIEF FOR THIRTY DAYS

The Department of Justice and the Secretary of Health, Education and Welfare, respectfully request leave to defer filing a supplemental brief until April 7, 1980. The reasons for this motion are as follows:

1. On January 24, 1980, the Department of Justice provided this Court with a brief which the Solicitor General had filed in *United States of America* v. *David Zbaraz,* No. 79-491 (Supreme Court). We called this Court's attention to the footnote which appears at pages 43-44 of that brief and stated that we would seek leave to file a supplemental memorandum explaining how that footnote affected this case within approximately two weeks.

2. In the course of preparing that memorandum, it became clear that any effort to amplify the arguments contained in the footnote or to extend them to areas other than abortion funding could have important ramifications for the Medicaid program as a whole. Accordingly, the Solicitor General has asked both the Civil Division and the

Department of Health, Education and Welfare to provide him with comprehensive memoranda on the subject so that he can define the contours of the government's position. Until this process is complete, the attorneys assigned to this case cannot fully inform this Court of the government's position.

Respectfully submitted,

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No. 77-2743

IN THE

UNITED STATES COURT OF APPEALS

FOR THE FIFTH CIRCUIT

CAROLYN RUSH (pseudonym),

Plaintiff-Appellee,

v.

DAVID POYTHRESS, Commissioner, Georgia Department of Medical Assistance and PATRICIA R. HARRIS, Secretary, Department of Health, Education and Welfare,

Defendants-Appellants.

On Appeal from the United States District Court for the Northern District of Georgia

SUPPLEMENTAL BRIEF FOR THE FEDERAL APPELLANTS

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CITATIONS

No. 77-2743

IN THE

UNITED STATES COURT OF APPEALS

FOR THE FIFTH CIRCUIT

CAROLYN RUSH (pseudonym),

Plaintiff-Appellee,

v.

DAVID POYTHRESS, Commissioner, Georgia Department of Medical Assistance and PATRICIA R. HARRIS, Secretary, Department of Health, Education and Welfare,

Defendants-Appellants.

On Appeal from the United States District Court for the Northern District of Georgia

SUPPLEMENTAL BRIEF FOR THE FEDERAL APPELLANTS

This case was argued and submitted on September 24, 1979. By letter dated January 24, 1980, the federal appellants requested the Clerk of this Court to provide the members of the panel with copies of a brief which the Solicitor General had just filed in *United States of America* v. *David Zbaraz, et al.*, No. 79-491 (Supreme Court). We asked the Clerk to direct the panel's attention to the footnote which appears at pages 43-44 of that brief and stated that we would seek leave to file a supplemental memorandum explaining the effect of that footnote upon this appeal.

The order from which this appeal was taken required the states to fund all medically necessary services falling within five broad categories and held that the treating physician's determination of medical necessity controls the state's obligation to pay. The Secretary raised two issues on appeal: whether the states do in fact have to pay for all medically necessary services within the five categories and whether the treating physician has the sole authority to define medical necessity. The development of policy which is reflected in the *Zbaraz* footnote plainly affects the disposition of the first issue. It has no bearing upon the second.

The first section of this brief will explain how and why the Secretary's interpretation of the Medicaid statute has evolved since the filing of this appeal so that portions of it no longer reflect government policy.[1] The second section will formally withdraw those portions of this appeal. The final section will identify the issues that remain in this case and explain why the withdrawal of one part of the Secretary's appeal does not affect the validity of the other.

A. The development of the Secretary's position focuses upon four statutory provisions: 42 U.S.C. 1396, 42 U.S.C. 1396a (a)(13)(B), 42 U.S.C. 1396a(a)(17) and 42 U.S.C. 1396d(a)(1)-(5). It took place primarily in the context of the three cases below.

1. In March of 1976, the Solicitor General filed a Memorandum for the United States as Amicus Curiae in *Beal* v. *Doe*, No. 75-554 (Supreme Court). That case presented the question of whether the Medicaid statute allowed the states to eliminate coverage of elective abortions. The memorandum cited § 1396 for the proposition that "[t]he principal objective of Title XIX is the furnishing of "medical assistance on behalf of [certain families and individuals] whose income and re-

[1] The attorneys who prosecuted this appeal did not know that the Secretary's views were evolving until her ideas had fully developed and found expression in the *Zbaraz* footnote. They notified this Court immediately.

sources are insufficient to meet the costs of necessary medical services." Memorandum, p. 5. It asserted that § 1396a (a)(13)B) and § 1396d(a)(1)-(5) require the states to provide those families and individuals with five kinds of medical care: (1) inpatient hospital services, (2) out-patient hospital services, (3) laboratory and x-ray services, (4) skilled nursing facility services, periodic screening and diagnosis of children, and family planning services, and (5) physician's services. Memorandum, p. 4. However, the memorandum treated § 1396a(a)(17) as authorizing the states to set some limitations on the types of services which they will cover under their Medicaid plans even when those services fall within the five mandatory categories. Memorandum, p. 5. It asserted that "Congress intended that the participating states would retain substantial flexibility in determining the extent, scope and duration of medicaid coverage, subject only to the requirement of reasonableness and other specific requirements of the Act." Memorandum, p. 6. It concluded that the states could reasonably exclude elective or unnecessary services from coverage. *Id.*

2. In August of 1977, the United States District Court for the Northern District of Georgia decided this case. The Secretary sought and obtained the Solicitor General's authorization to file an appeal which would extend the *Beal* interpretation of § 1396a(a)(17) to a situation in which the treating physician had determined that the excluded service was medically necessary for a particular Medicaid recipient. Since the *Beal* opinion indicated that serious statutory questions would arise if the states invoked § 1396a(a)(17) to eliminate coverage of medically necessary services, the Secretary argued that the states may exclude on an across-the-board basis, services which a treating physician could determine are medically necessary only if they can sustain a heavy burden of proof on the issue of reasonableness. The Secretary also argued that in any event, transsexual surgery was not generally a medically necessary mode of treatment. Opening Brief, pp. 13-14.

3. In April of 1979, the United States District Court for the Northern District of Illinois invalidated the federal statute which restricts the public funding of abortions. The Court held that the equal protection component of the Due Process Clause of the Fifth Amendment requires the government to pay for all abortions deemed medically necessary by the treating physician and performed prior to viability. *Zbaraz* v. *Quern*, 469 F.Supp. 1212 (N.D.Ill. 1979). In preparing the direct appeal to the Supreme Court, the Solicitor General asked the Secretary of Health, Education and Welfare whether the states would have discretion to exclude medically necessary abortions from coverage in the absence of the federal funding restrictions. Abortions may fall within at least three of the five mandatory categories and services—inpatient hospital, outpatient hospital and physicians services. That request prompted the Secretary to re-examine the statute and its legislative history with respect to medical necessity. As a result of an extensive re-examination of the issue, the Secretary concluded that the position advanced in *Beal* and *Rush* was incorrect in so far as it suggested that the Medicaid statute and its implementing regulations permit states to eliminate entirely specific types of services within the five mandatory categories from Medicaid coverage on grounds other than medical necessity. The Secretary concluded that the states could eliminate types of services from coverage only on the basis of medical necessity and not on the basis of some looser standard of reasonableness.[2] In her view, 42 U.S.C. 1396a(a)(17) does not override the provisions of the statute that require the states to provide "at least" the services falling

[2] The Secretary also reviewed extensively HEW's prior administrative practice and concluded that, with a few limited exceptions, the Department had permitted states to exclude from coverage specific types of services falling within the mandatory categories only under a medical necessity standard. Thus, the practical effect of the evolution of the Secretary's interpretation of the Medicaid act should be very small.

within the five mandatory categories.[3] The Solicitor General presented these views to the Supreme Court in *Zbaraz* and we promptly transmitted a copy of that brief to this Court.

B. The Secretary's re-examination of the Medicaid statute requires the withdrawal of two arguments that we presented to this Court. The first concerns the proper interaction between 42 U.S.C. 1396a(a)(13)(B), 42 U.S.C. 1396a(a)(17) and 42 U.S.C. 1396d(a)(1)-(5). The second concerns the proper interpretation of the phrase "necessary medical services" which appears in 42 U.S.C. 1396.

1. In our opening brief to this Court, we argued that Georgia could exclude transsexual surgery from coverage under its state Medicaid plan even though hospital and physician's services fall within the five mandatory categories of treatment. We asserted that 42 U.S.C. 1396a(a)(17) permits each state to define the extent to which it will provide medical assistance under its plan and that the state's authority to limit the scope of its coverage extends to the five mandatory service categories. We further contended that § 1396a(a)(17) establishes the criteria for judging a state's decision to eliminate a particular kind of service from coverage: reasonableness and consistency with the objectives of the Medicaid statute.

[3] The Department's regulations also delineate the scope of discretion States have in excluding services within the mandatory categories from coverage. These regulations prohibit States from "...arbitrarily deny[ing] or reduc[ing] the amount, duration, or scope of a required service [one within the mandatory categories] solely because of the diagnosis, type of illness, or condition." 42 C.F.R. 440.230(c)(1), as corrected, 43 Fed. Reg. 57253 (December 7, 1978). See also 42 C.F.R. 440.230(c)(2). As explained in the preamble when the Department initially issued this regulation, the word "arbitrarily" was added only to specify that the regulation does not prohibit states from setting reasonable limitations "appropriate to medical necessity or utilization review." 39 *Fed. Reg.* 16970 (May 10, 1974). Thus, the regulation prohibits States from excluding from coverage medically necessary services within the mandatory categories based upon the diagnosis or condition of the patient.

After exhaustively re-examining the question, the Secretary concluded that the legislative history of the Medicaid act emphasizes the provision of a minimum program of medical benefits consisting of services within the five mandatory categories listed in 42 U.S.C. 1396d(a)(1)-(5). *See* 42 U.S.C. 1396a(a)(13)(B). The Secretary further concluded that the language and legislative history of 42 U.S.C. 1396a(a)(17) indicates that Congress intended to give the states broad discretion to set eligibility-related requirements—e.g., the level of income and resources that individuals could have and still be eligible, or the comparability of financial eligibility requirements for each categorical group of Medicaid recipients—but that Congress did not intend to authorize the states to exclude types of medically necessary services from coverage. She therefore concluded that states must pay for all medically necessary types of services falling within the mandatory categories unless Congress relieves them of that responsibility by adopting its own funding restrictions. These views are stated in the *Zbaraz* footnote and necessitate the withdrawal of the arguments presented on pages 9-14 of our opening brief.

2. In our letter of August 10, 1979, we called this Court's attention to the decision in *Preterm* v. *Dukakis*, 591 F.2d 121 (1st Cir. 1979). In that case, the court viewed the words "necessary medical services" as forming part of the definition of the beneficiaries of the Act rather than imposing any substantive requirement on the states. *Id.* at 124-125. At oral argument, we asked this Court to follow that strict gramatical reading of 42 U.S.C. 1396.[4]

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[4] 42 U.S.C. 1396 provides in pertinent part:

> For purpose of enabling each State, as far as practicable under the conditions of such State, to furnish (1) medical assistance on behalf of families with dependent children and of aged, blind or disabled individuals, whose income and resources are insufficient to meet the cost of necessary medical services * * * there is hereby authorized, to be appropriated for each fiscal year a sum sufficient to carry out the purposes of this subchapter * * *.

Upon re-examination, the Secretary has concluded, in agreement with the District Court's decision in this case, that the phrase "necessary medical services" does not have such a limited application. Rather, it constitutes the legislative statement of the purpose of the Act. The Secretary also determined that it constitutes statutory authority for permitting the states to eliminate from coverage unnecessary, although perhaps desirable, medical services falling within the five mandatory categories. Again, these views have been stated in the *Zbaraz* footnote and require the withdrawal of our request on behalf of HEW, that this Court follow *Preterm* in finding that the words "necessary medical services" do not define the scope of the states' obligations under the Act.

C. The Secretary's conclusion that the states must fund all medically necessary type of services falling within the five mandatory categories requires us to withdraw the arguments advanced in support of our first issue on appeal. However, HEW's re-examination of the Medicaid statute and its legislative history have reinforced its belief that the treating physician is not the sole judge of medical necessity. Accordingly, the second issue on appeal remains for decision.

The Supreme Court has held that the Medicaid Act does not require the states to pay for medically unnecessary services. *Beal* v. *Doe*, 432 U.S. 438 (1977). Thus, the critical question is who judges medical necessity. The Secretary has traditionally allowed the states to decide that particular types of services are not medically necessary and to eliminate them from coverage on an across-the-board basis. Indeed, the Department's regulations specifically state that "[a]ppropriate limits may be placed on services based on such criteria as medical necessity***" 42 C.F.R. 440.230(c)(1), as corrected 43 Fed. Reg. 57253 (December 7, 1978). The regulations do prohibit the states from "arbitrarily deny[ing] or reduc[ing] the amount, duration or scope of a required service solely because of the diagnosis, type of illness or condition." *Id.* However, as ex-

plained in footnote 3, *supra,* when that regulation was first promulgated, the preamble explained that "arbitrarily" means based on considerations other than medical necessity or utilization review. 39 Fed. Reg. 16970 (May 10, 1979). Thus, the regulation permits States to make reasonable across-the-board determinations about the medical necessity of particular types of services, even within the mandatory categories, and to exclude them from Medicaid coverage on that basis. For example, States have been permitted to exclude cosmetic surgery from coverage.

The Secretary has generally permitted the states to exclude methods of treatment as unnecessary if they are experimental or not generally recognized as effective within the medical community. In the instant case, the Department submitted the affidavits of two psychiatrists both of whom have extensive experience in treating transsexualism and both of whom have serious doubts as to the safety and efficacy of surgery as a form of therapy.[5] Accordingly, the Department adheres to its original position that this case could not properly have been decided on the plaintiff's motion for summary judgment and should be remanded for a determination as to whether Georgia's decision to exclude transsexual surgery and the Secretary's decision to

[5] During her re-examination of the medical necessity question, the Secretary did not decide the extent to which the availability of alternate forms of treatment could form the basis for a permissible exclusion. A decision on this point is not essential to the disposition of this appeal because Georgia has plainly excluded transsexual surgery from coverage on the grounds that it is experimental—*i.e.,* not generally recognized as effective.

approve Georgia's plan constitute valid administrative decisions in accordance with the standards set forth in *Citizens to Preserve Overton Park* v. *Volpe,* 401 U.S. 402 (1971).

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April, 1980

October 1966 Preliminary

Questions and Answers

on the

MEDICAL ASSISTANCE PROGRAM

U.S. DEPARTMENT OF
HEALTH, EDUCATION, AND WELFARE

Welfare Administration
Bureau of Family Services

PURPOSE AND GOALS

QUESTION 1

What is the medical assistance program?

Answer: The medical assistance program is title XIX of the Social Security Act. It was authorized by an amendment to the Act and was signed into law by President Johnson on July 30, 1965 (Public Law 89-97).

QUESTION 2

What is the goal of the medical assistance program?

Answer: Medical care of high quality that will be readily available to persons unable to pay for it.

QUESTION 3

How does a State achieve this goal?

Answer: A State achieves this goal by providing the necessary medical care for persons who need it but do not have sufficient income and resources to pay the full cost. The State agency and its local units work with other agencies, organizations, and professional groups in furthering the development and maintenance of adequate resources for the provision of medical care for all persons throughout the State. Specifically, the agency is concerned with eligible persons who need assistance in meeting the costs of their care. The agency sets standards designed to ensure care of high quality, establishes policies and procedures, and makes other arrangements to enable individuals to obtain the care and services they need. It provides social services to assist families in recognizing the need for medical care, in obtaining care promptly, and in making

necessary adjustments in social factors related to medical care. It determines eligibility for assistance, authorizes the expenditures, and makes payments for the care and services received.

QUESTION 4

What are the basic differences between the medical assistance program (title XIX) and the program of health insurance for the aged (title IVIII, or medicare)?

Answer: Title XIX is a Federal-State assistance program, designed to provide medical care for needy persons of all ages under a definition of need defined by each State. Eligibility is determined for the individual or family according to State provisions. This medical assistance program is administered by the States and is financed in part by the State (or State and local) governments and in part (50-83 percent, depending on State average per capita income) by the Federal Government. Since each State determines eligibility and benefits, there will be differences—State by State in who is eligible and for what benefits.

Title XVIII is a federally administered insurance program for the aged, affording two kinds of benefits for persons aged 65 or older: hospital insurance (for hospitalization and related care) and voluntary medical insurance (for physicians' services and some other medical services). Eligibility is a right based on the social insurance principle, and benefits are the same throughout the Nation. The basic program of hospital insurance is financed by deductions from employees' wages and matching taxes paid by employers; for voluntary medical insurance, the individual currently pays $3 a month, and the Federal Government pays the same amount. The Social Security Administration is responsible for formulating policy and administering the program.

QUESTION 5

How does a State's medical assistance program relate to the Federal program of medicare?

Answer: The medical assistance program complements the health insurance provisions by paying the deductible amounts for needy, aged persons who are insured. It supplements the insurance program by providing services in addition to those made available under the insurance provisions and by helping States provide medical services to persons under age 65.

MEDICAL CARE SERVICES

QUESTION 31

What medical services are included as "medical assistance"?

Answer: They will vary from State to State. As a minimum, the State must provide some institutional and some noninstitutional care. Because of the requirement that the full cost of any deductible imposed under the Federal insurance program shall be paid by the State agency for old-age assistance recipients, the State must also provide inpatient hospital services, outpatient hospital diagnostic services, and the first 3 pints of whole blood (if blood is not available to the patient from other sources). Since persons aged 65 and over will thus receive these three services, all persons in the State who are eligible for the medical assistance program must receive the same items, in the same amounts. This principle of equality is a special feature of the medical assistance program.

In addition, a State may include any or all of the 15 items identified in the Act (and listed under answers 33 and 34) as medical assistance care and services. By July 1, 1967, a State must include at least five basic services.

QUESTION 32

What is meant by "some institutional and some noninstitutional" care?

Answer: No precise definition of "some," in this context, is found either in the law or in the policies interpreting the law developed by the Welfare Administration of the Department of Health, Education, and Welfare. State plans that have been approved provide a sufficient number of days of hospital care to meet the needs of most people. They also provide, in general, noninstitutional care sufficient in amount, duration, and scope to promote health and provide treatment that will prevent the need for more expensive inpatient care.

QUESTION 42

The Act refers to medical assistance of "high quality." How can high quality be attained in a system that of necessity will vary significantly from State to State?

Answer: It is true that there will be State-to-State differences in the amount, duration, and scope of medical care and services. The high-income State may be able to provide practically all the services that anyone could need. For low-income States a medical assistance program may not be possible for some years. The middle-income State may be able to guarantee only a modest number of days of hospitalization, a limited number of physician's visits; it may be able to provide no dental services or eyeglasses. Differences among States in adequacy of financial assistance, medical assistance, and social services have characterized the grant-in-aid programs from the beginning. Nevertheless, the new legislation clearly calls for concerted efforts by both Federal and State administrators to develop a program that is sound, acceptable, and working towards excellence.

Even if a State's funds are so limited that, in the beginning, the program can reach only those persons eligible for financial assistance, the service provided can be of high quality. The fee structures for physicians can be set high enough to encourage the community's best practitioners to take part. The greater competence of men who are certified by a specialty Board or eligible for Board certification, or who are otherwise accepted by the medical community as qualified specialists in the field, should be recognized in the fee structure. This recognition will help ensure that eligible persons will receive medical care and services from specialists for conditions usually considered to require specialist attention, at least to the extent the general population of the community does. The State's Medical Care Advisory Committee, representing key professional groups, will be a potent factor in ensuring high quality.

Accommodations in hospitals may not be less desirable than the semiprivate ones assured patients under medicare—that is, two-bed, three-bed, or four-bed accommodations. Beginning July 1, 1967, hospital fees must be based on the reasonable cost of inpatient hospital services. All these measures and others, are designed to ensure high-quality care.

[U.S. Department of Health, Education, and Welfare] D-1100

Handbook of Public Assistance Administration
Supplement D
Medical Assistance Programs

Development of a Comprehensive Program

D-1100 6/17/66

D-1100. Development of a Comprehensive Program

Section 1903(e) of the Social Security Act reads as follows:

> "The Secretary shall not make payments under the preceding provisions of this section to any State unless the State makes a satisfactory showing that it is making efforts in the direction of broadening the scope of the care and services made available under the plan and in the direction of liberalizing the eligibility requirements for medical assistance, with a view toward furnishing by July 1, 1975, comprehensive care and services to substantially all individuals who meet the plan's eligibility standards with respect to income and resources, including services to enable such individuals to attain or retain independence or self-care."

Section 1903(e), read in context with other statutory provisions related to program goals, effective administration, and quality of care, requires progressive steps in the direction of a comprehensive scope of medical care and services for families and individuals whose limited income and resources are insufficient to purchase them.

The law requires the Secretary, as a condition to continued payment of Federal grants-in-aid, to satisfy himself of State effort in this direction.

State effort must be evident in the following areas until appropriate goals are reached:

1. Strengthening of professional medical and supporting staff in the administration and supervision of the plan. (This includes an adequate number of staff, professional qualifications and arrangements for staff development.)

2. Broadening of scope of services made available.

3. Liberalizing of eligibility requirements to admit additional low-income families and persons to the program.

4. Intensifying social services focused on appropriate utilization of medical care and services, and on enabling recipients to attain or retain independence or self-care.

The law, as implemented by the policies in this Handbook Supplement, makes specific provision for progressive improvement in breadth and depth of the medical assistance program, quality of care and services, and adequacy of administration.

Handbook of Public Assistance Administration
Supplement D
Medical Assistance Programs

Amount, Duration, and Scope of Assistance

D-5100 4/3/67

D-5130. Criteria for the Administration of the Plan

1. The items of medical and remedial care and services which the State includes in its plan are sufficient in amount, duration, and scope reasonably to achieve their purpose.

2. Criteria to assure high quality of the care and services provided under the plan include the following:

a. Provision is made for use of specialist and consultative medical service.

b. Provision is made for necessary transportation of recipients to and from the suppliers of medical and remedial care and services.

c. Priority is given to the use of available semi-private accommodations (as defined in section 1861(v)(4) of the Social Security Act) for hospitalized recipients.

d. Long-term care of patients in medical institutions is provided in accordance with procedures and practices that include the following: [omitted]

e. Standards for medical and remedial care and services incorporate, as appropriate, standards in other specialized, high quality programs, particularly the program of crippled children's services.

f. In the provision of drugs,

(1) The State uses professional pharmaceutical consultation;

(2) Standards and procedures provide for dispensing of drugs at the lowest cost consistent with quality; and

(3) There is review and analysis of drug bills, including the compilation of statistics with respect to types, quantities, and cost of drugs dispensed.

g. There is a specific plan for a continuous evaluation of the utilization and quality of medical and remedial care and services provided under the State plan.

h. Methods exist that assure that direct service workers and their supervisors are knowledgeable about health problems and ways to assist people to secure medical and remedial care and services.

i. Direct service workers are kept currently informed of significant medical information concerning their clients.

3. The agency utilizes its staff and advisory committee to plan and promote broadening of the scope of medical and remedial care and services toward the goal of comprehensive care.

4. If the State plan includes medical and remedial care and services in relation to family planning, as defined in D-5141, item 15b, the agency's policies and procedures for staff, and practices thereunder, assure to individuals freedom from coercion or pressure of mind or conscience and freedom of choice of method, so that individuals can choose in accordance with the dictates of their consciences.

D-5140. Interpretation

The passage of title XIX marks the beginning of a new era in medical care for low income families. The potential of this new title can hardly be over-estimated, as its ultimate goal is the assurance of complete, continuous, family-centered medical care of high quality to persons who are unable to pay for it themselves. The law aims much higher than the mere paying of medical bills, and States, in order to achieve its high purpose,

will need to assume responsibility for planning and establishing systems of high quality medical care, comprehensive in scope and wide in coverage.

In a well-balanced program, whether or not the scope of services is comprehensive, institutional and non-institutional care should be mutually supportive, allowing the patient to move into the institution and back to the community according to his medical needs. A variety of non-institutional services is needed to assure continuity of care. A system which provides the patient with appropriate care when and where needed not only promotes quality but is also economical. For example, to provide physicians' services, but not drugs, is self-defeating, and costly in both human and fiscal terms.

The medical assistance made available must be sufficient in amount, duration, and scope reasonably to achieve its purpose. A token service which can only be ineffective on the one hand, and wasteful of funds on the other, will not be considered satisfactory. Institutional care should not be less in amount than would be required by most of the persons needing this kind of care. As an example, if a substantial number of persons admitted to hospitals required 21 or more days care per admission, the State's standard should not provide for a fewer number of days. In appraising the amount, duration, and scope of medical assistance to be provided, consideration will need to be given to the stage of development of the State's program and the availability of medical care and services in the State.

Non-institutional care should include medical services in amounts which will promote health and provide treatment to persons in lieu of more expensive inpatient care.

Limitations may not be set by eliminating certain groups of patients or certain diagnoses from coverage (except patients under 65 years of age in institutions for tuberculosis or mental diseases and patients under 21 in nursing homes). Neither may limitations be set by making eligibility for one kind of medical

care dependent on the receipt of another kind. For example, non-institutional care may not be limited to persons discharged from institutional care.

In addition to the items of medical and remedial care and services required to be included in the State plan (D-5120, items 1 and 2), any or all of the 15 items enumerated in section 1905(a) of the Act may also be included. These 15 items are defined below. In all these items, the following three definitions apply, except to the extent the context otherwise requires.

1. "Patient" is defined as an individual who is in need of and receiving professional services directed by a licensed practitioner of the healing arts toward maintenance, improvement, or protection of health or alleviation of disability or pain.

2. "Inpatient" is a patient who has been admitted to a hospital, nursing home, or other medical institution on recommendation of a physician or dentist and is receiving room, board and professional services in the institution on a continuous 24-hour a day basis.

3. "Outpatient" is a patient who is receiving his professional services at an organized medical facility, or distinct part of such facility, which is not providing him with room and board and professional services on a continuous 24-hour a day basis.

D-5141. Definitions

1. *Inpatient Hospital Services (Other Than Services in an Institution for Tuberculosis or Mental Diseases)*

The term "inpatient hospital services" means those items and services ordinarily furnished by the hospital for the care and treatment of inpatients, which are provided under the direction of a physician or dentist in an institution maintained primarily for treatment and care of patients with disorders other than tuberculosis or mental diseases and which is licensed or formally approved as a hospital by

an officially designated State standard-setting authority; and is qualified to participate under title XVIII of the Social Security Act, or is determined currently to meet the requirements for such participation; and has in effect a hospital utilization review plan applicable to all patients who receive medical assistance under title XIX.

2. *Outpatient Hospital Services*

"Outpatient hospital services" are defined as those preventive, diagnostic, therapeutic, rehabilitative, or palliative items or services furnished by or under the direction of a physician or dentist to an outpatient by an institution licensed or formally approved as a hospital by an officially designated State standard-setting authority; and is qualified to participate under title XVIII of the Social Security Act, or is determined currently to meet the requirements for such participation.

* * * *

5. *Physicians' Services, Whether Furnished in the Office, the Patient's Home, a Hospital, a Skilled Nursing Home, or Elsewhere*

The term "physicians' services" is defined as those services provided, within the scope of practice of his profession as defined by State law, by or under the personal supervision of an individual licensed under State law to practice medicine or osteopathy.

* * * *

9. *Clinic Services*

"Clinic services" are defined as preventive, diagnostic, therapeutic, rehabilitative, or palliative items or services furnished to an outpatient by or under the direction of a physician or dentist in a facility which is not part of a hospital but which is organized and operated to provide medical care to outpatients.

D-5142. Expansion of Program

States which initially limit the scope of their program to the minimum of "some institutional and some non-institutional care" will be expected to proceed at once, through a series of planned steps, to expand the scope of care to cover the five basic services which are required by July 1, 1967. As soon as these five services have been covered, States will need to proceed with further expansion in order to reach the goal of comprehensive medical care by 1975. Comprehensive care includes all preventive, diagnostic, curative and rehabilitative services or goods furnished, prescribed or ordered by a recognized practitioner of the healing arts within the scope of his practice. It is expected that most States in the early stages of development under title XIX, will concentrate on the provision of diagnostic and curative services, but as expansion takes place, these services should be augmented with preventive and rehabilitative services. Since the areas of prevention and of rehabilitation are vast and largely unexplored by States, beginnings may be made by providing vaccination and inoculation services and selected screening procedures for certain conditions. As States gain experience in the provision of medical and remedial care and services, they should be able to make increasing use of the rapid advances in medical knowledge and skills in the field of rehabilitation.

D-5143. Equality of Medical Care

A basic concept of title XIX is that of equality of medical and remedial care and services. Its purpose is to erase the differences in the various categories in regard to care and services. What this means in actual operation is that AFDC children will be treated the same as all other recipients. In medical assistance, the categorically needy are considered one indivisible group, and the same services, in the same amount and quality, and of the same duration, must be made available to all within the group. The only exceptions are skilled nursing home services, which may be limited to persons age 21 or over,

and services to persons in institutions for tuberculosis or mental diseases which may be limited to the matchable group of persons age 65 or over.

Similarly, the medically needy are considered an indivisible group, and there must be equality in the amount, duration, and scope of medical and remedial care and services provided all persons within this group, with the exceptions noted above.

There need not, however, be equality between the two groups. That is, the care and services offered the categorically needy may exceed, but may not be less than, those offered the medically needy.

The principle of equality requires that the States provide inpatient hospital services, outpatient hospital diagnostic services, and the first three pints of whole blood, if not available from other sources, for all recipients, since the law requires that States, under title XIX, be responsible for meeting the deductibles imposed under part A of title XVIII.

D-5144. Quality of Medical Care

The Congress has made very clear its intent that the medical and remedial care and services made available to recipients under title XIX be of high quality and in nowise inferior to that enjoyed by the rest of the population. To make sure that the concept of quality is not lost sight of, the law requires the States to establish methods and standards to assure high quality care. In meeting this requirement, the State agency should look to its medical care advisory committee for help. This committee can also advise the State agency in planning utilization studies. The State agencies for Crippled Children's Services and Maternal and Child Health Services are other important resources in assisting the State agency to establish high standards of care.

In providing services which at least meet the specifications identified in the definitions contained in the foregoing part of

this seciton, States will be assured of sound basic quality. Beyond this, services of specialists need to be readily available. The State, in setting standards for specialists, should require that specialists, in order to participate in the program, be certified by the appropriate medical or osteopathic specialty board; or be qualified for admission to the examinations of the appropriate board; or hold an active staff appointment in a hospital approved for training in the appropriate specialty with privileges in that specialty. Dental specialists should be Board certified or Board eligible or otherwise recognized by a dental society of the State as a qualified specialist in the field.

A State which provides for the purchase of prostheses, appliances or aids should establish standards for the selection, fitting and training in the use of the devices. The standards should be formulated with the help of the medical care advisory committee, utilizing available standards such as those established under the State crippled children's services, physical restoration programs under Vocational Rehabilitation, etc.

Provision for paying the costs of transportation, determined by the agency to be necessary for obtaining medical care and services, is an important factor in achieving both equality of care and high quality of care. Recipients who live at a distance from the supplier of medical service may need assistance in meeting the costs of transportation. Assurance that transportation costs will be met also assures that the services of specialists and facilities of high quality throughout the State and outside the State are available as needed to all recipients, and eliminates reliance on inferior resources.

In order to secure a high quality of medical and remedial care and services, it will be necessary for States to establish realistic schedules of compensation for services, which should be commensurate with "reasonable cost" or "reasonable charge" and not inconsistent with prevailing community payments, such as those under title XVIII or Blue Shield plans.

The purpose of a title XIX program is to get medical care without delay to eligible people who need it. In fulfilling this purpose, the local caseworker is a key figure. Both caseworkers and their supervisors must be sensitive to and informed about medical problems and how to assist individuals and families to get the care necessary, as well as how to work with social problems related to medical problems. The caseworker is in a unique position to assist the medical disciplines to avoid the waste, both human and financial, of fragmented, haphazard medical care. Through his knowledge of the family and of the individual, he can promote the realization of the goal of planned, total family-centered care. This means that all the factors which militate against the well-being of the recipient, both as an individual and as a family member, are dealt with in a planned, purposeful way. It means that all needed supportive services are brought to bear and coordinated in a unified effort between the health professions and the agency.

D-5150. Federal Financial Participation

Federal financial participation is available in expenditures for medical or remedial care and services under the State plan which meet the definitions, items 1 through 15, in D-5141 (also see D-5800).

Drugs.—With respect to "prescribed drugs," as defined in D-5141, item 12a, Federal financial participation is available in expenditures for drugs dispensed by licensed pharmacists and, when dispensed by legally authorized practitioners, where no adequate pharmacy services exist or are available when needed, and the practitioner dispenses such drugs on his written prescription, and retains records thereof.

Federal financial participation in expenditures for care and services for patients in institutions for tuberculosis or mental diseases is limited to persons 65 years of age or over.

Title XIX—STATE PLAN—LIMITATIONS ON AMOUNT, DURATION AND SCOPE OF SERVICES

STATE: Georgia **Attachment 3.1A**
Page 2a

Effective 8-1-75

LIMITATIONS:

5 PHYSICIANS' SERVICES

A. The Medicaid Office has developed a prior approval mechanism through the Georgia Medicaid Administration by at least one week prior to the provision of service for those physicians who *wish* to prior authorize a treatment plan. If a physician receives prior approval for a treatment plan, the subsequent claims will not be subject to retrospective peer review and possible denial. Any of the following *may* be submitted for prior approval.

1. Home or office visits in excess of one (1) per month.

2. More than one (1) referral of a recipient to a consulting physician in one month.

3. Outpatient hospital visits in excess of one (1) per month.

4. More than one (1) visit per month to a recipient in a skilled nursing facility or intermediate care facility.

5. Any service identified in The Georgia Medicaid Policy and Procedures Manual for Physician Services which requires additional documentation with the claim.

6. Any service identified in The Georgia Medicaid Policy and Procedures Manual for Physician Services which is identified for automatic peer review.

B. The following *must* be submitted for prior approval.

1. T & A, unless medical necessity does not provide sufficient time for approval. In those cases, the claim will be subject to peer review.

2. Removal of keloids, unless medical necessity does not provide sufficient time for approval. In those cases, the claim will be subject to peer review.

3. Osteopathic manipulative therapy (OMT).

4. Physical therapy which exceeds three treatments per week for eight weeks or a total of 24 treatments.

5. Services which are otherwise excluded by policy and procedure but are allowed under Georgia law.

C. Home, office, outpatient hospital, or nursing home visits are limited to one per month with the following exceptions; a medical emergency or acute illness exists; additional visits are required related to the original primary diagnosis chronic cases; or the primary care physician refers the recipient to needed specialist(s) for additional visit(s).

C. Medcosonolator rendered by the physician—payment will made of 1 daily for 5 days for mild inflammatory conditions if prior approval is given by Medicaid Administration prior to rendering of services.

D. Medcotherm rendered by the physician—payment will only be made for treatment 5 times a month for no more than 3 months if prior approval is given by Medicaid Administration prior to rendering of services.

E. Reimbursement will be limited to the following unless prior approval is obtained from the Medicaid Director at least one week prior to rendering service.

1. Vitamin B12 injections only in the treatment of Pernicious Anemia and Malabsorption Syndrome.

2. ACTH injections only in the treatment of Pituitary Insufficiency or Ulcerative Colitis.

3. Gonadatropin injections only in diagnoses other than obesity.

4. Pyralgin injections only for treatment of febrile convulsions of children when other medications have been found to be ineffective or in malignant diseases when fever cannot be controlled by any other means.

5. Antibiotic injections only when given on a rigid treatment regimine.

F. One urinalysis on the initial office visit, regardless of the diagnosis. Thereafter, urinalysis will not be allowed unless it is directly related to the diagnosis.

G. The Medicaid Program will not provide reimbursement for more than one physician inpatient hospital visit per day to a recipient unless a medical necessity exists. Physicians may request prior approval for additional visits. Clarifications are noted in the Ga. Medicaid Physicians Policy and Procedures Manual.

H. Cosmetic Surgery—Dermabrasions, hair transplants, face lifts, Ileo-bypass procedures for weight reduction, scars, Rhinoplasty—are not covered.

I. No reimbursement will be made for experimental surgery, e.g., trans-sexual operations.

J. Outpatient psychotherapy is limited to a maximum of $250 per patient per calendar year.

Eyeglasses, optical services and contact lenses provided for eligible recipients 21 years of age and over where both the visual examination was completed and a prescription for eyeglasses or contact lenses written prior to March 29, 1975; if such services were rendered under the policies and in conformity with the State Plan.

Prostetic lenses and related services are covered for all eligible recipients. This would include the provision of eyeglasses or contact lenses, as appropriate to an individual lacking the organic lens of the eye because of surgical removal or congenital absence.

6. PODIATRY SERVICES

A. The Medicaid Program will not provide reimbursement for a Podiatrist for more than one home, outpatient hospital, or office visit per month for a recipient unless the provider has received prior approval.

B. The Medicaid Program will not provide reimbursement for more than one inpatient hospital podiatrist visit per day to a recipient unless the podiatrist has received prior approval.

C. The Medicaid Program will not provide reimbursement for the following services of a podiatrist:

1. *Flatfoot*—The evaluation or nonsurgical treatment of a flatfoot condition regardless of the underlying pathology.

2. *Subluxation*—The evaluation of subluxation of the foot and nonsurgical measures to correct the condition or to alleviate symptoms.

3. *Routine Foot Care*—Routine foot care for ambulatory or bedridden patients includes, cutting or removal of corns, warts, or callouses, the trimming of nails and other hygenic and preventive maintenance care in the realm of self-care such as cleansing and soaking, the use of skin creams.

4. *Supportive Devices*—Orthopedic shoes other than shoes that are integral part of a brace and arch supports. An orthopedic shoe that is built in a leg brace is reimbursable. Biomechanical orthotics are not reimbursable.

Title XIX—STATE PLAN LIMITATIONS ON AMOUNT, DURATION AND SCOPE OF SERVICES

STATE: Kansas **Attachment 3.1A**

Effective 10-1-78

3.1A Limitation

 # 1. Inpatient Hospital Services

3.1-A Limitation

#1. Inpatient Hospital Services

All out-of-state inpatient care is subject to prior authorization except for emergency care and care within hospitals in Texas, Colorado, Nebraska, Oklahoma, Missouri, Iowa, and Arkansas, whose services are routinely utilized by Kansas recipients. No payment will be made for inpatient admissions from midnight Thursday through midnight Saturday, except in the case of an emergency admission. Any procedure which can be completed within a twenty-four (24) hour period is excluded from the nonadmission policy of Thursday midnight through Saturday midnight. Inpatient stays longer than the 50th percentile require written information confirming medical necessity.

Abortions are covered when necessary because the life of the mother is endangered if the fetus is carried to term, or when performed upon a victim of rape or incest and it has been reported to appropriate authorities within 60 days of the incident. Required documentation must be attached to all claims submitted.

Abortions will not be covered which would result in severe and long-lasting physical health damage to the mother if the pregnancy were carried to term.

Inpatient hospital stays for substance abuse treatment will not be covered unless provided in a treatment program certified by the drug and alcohol abuse section of SRS.

3.1-A Limitation

#5. Physician's Services

Hospital visits are not to exceed those allowable days for which the hospital is paid. Office visits are limited to three per month unless supported by written documentation confirming medical necessity. Adult Care Home visits are limited to one per month unless supported by written documentation confirming medical necessity. Office visits for psychiatric services are limited to three per month unless supported by written documentation confirming medical necessity. Medical necessity for mental, emotional and behavioral conditions shall be defined "likely to do physical injury to himself, herself, or others", or for recipients needing psychiatric care in situations not life-endangering but medically necessary more often than three (3) times monthly, prior authorization is needed. Surgery for cosmetic purposes is not payable.

Services to the hard of hearing are limited to ear examination by the physician and testing of hearing acuity by the physician ear specialist.

Abortions are covered when necessary because the life of the mother is endangered if the fetus is carried to term, or when performed upon a victim of rape or incest and it has been reported to appropriate authorities within 60 days of the incident. Required documentation must be attached to all claims submitted.

Abortions will not be covered which would result in severe and long-lasting physical health damage to the mother if the pregnancy were carried to term.

State: Kentucky

Attachment 3.1A
Page 7.2

	Service	Categorically Needy	Medically Needy
5.	Physicians' services whether furnished in the office, the patient's home, a hospital, a skilled nursing facility or elsewhere	Provided PA* ☐ No limitations ☒ With limitations*	☒ Provided PA* ☐ No limitations ☒ With limitations* ☐ Not provided
6	Medical care and any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law		
	a. Podiatrists' Services	☐ Provided ☐ No limitations ☐ With limitations* ☒ Not provided	☐ Provided ☐ No limitations ☐ With limitations* ☒ Not provided
	b. Optometrists' Services	☒ Provided PA* ☐ No limitations ☐ With limitations* ☐ Not provided	☒ Provided PA* ☐ No limitations ☐ With limitations* ☐ Not provided
	c. Chiropracters' Services	☐ Provided ☐ No limitations ☐ With limitations ☒ Not provided	☐ Provided ☐ No limitations ☐ With limitations* ☒ Not provided
	d. Other practitioners' Services	☒ Provided (Identified on attached sheet with description of limitations, if any) ☐ Not provided	☒ Provided (Identified on attached sheet, with description of limitations, if any) ☐ Not provided

* Description provided on attached sheet.

Effective 4-1-76

5. Physician's Services (Limitations apply to both categories)

A. Coverage for certain initial and extensive visits is limited to two visits per patient per physician per calendar year. This limitation applies only to the following specific procedures:

9000	INITIAL office visit, ROUTINE, new patient or new illness, history and examination.
9001	INITIAL (or subsequent) office visit, COMPLETE diagnostic history and physical examination, ESTABLISHED PATIENT OR MINOR CHRONIC ILLNESS, including initiation of diagnostic and treatment programs.
9002	INITIAL (or subsequent) office visit, COMPLETE, diagnostic history and pnysical examination, NEW PATIENT OR MAJOR ILLNESS, including initiation of diagnostic and treatment programs.
9006	FOLLOW-UP office visit, PROLONGED, over and above 9005.
9007	FOLLOW-UP office visit necessitating COMPLETE reexamination and re-evaluation of patient as a whole (continuing illness).
9010	INITIAL home visit, ROUTINE, new patient or new illness, history and examination.
9011	INITIAL home visit, COMPLETE diagnostic history and physical examination, ESTABLISHED PATIENT or MINOR CHRONIC ILLNESS, including initiation of diagnostic and treatment programs.
9012	INITIAL home visit, COMPLETE diagnostic history and physical examination, NEW PATIENT or MAJOR ILLNESS, including initiation of diagnostic and treatment programs.

B. Outpatient psychiatric service procedures rendered by other than board-eligible and board-certified psychiatrists are limited to four (4) such procedures per patient per physician per calendar year.

C. Coverage for laboratory procedures performed in the physician's office is limited to those procedures listed on the physician's laboratory benefit schedule.

D. Pre-authorization is required for those patients, "locked in" to one physician and one pharmacy, who require services in excess of 4 prescriptions and four physicians office visits per month.

E. The cost of preparations used in injections is not covered.

F. Physician—patient telephone contacts are not covered.

Effective 1-1-79

Abortion service are reimbursable under the Medical Assistance Program only when service to provide an abortion or induce miscarriage is, in the opinion of a physician, necessary for the preservation of the life of the woman seeking such treatment. Any request for program payment for an abortion or induced miscarriage must be justified by a signed physician certification documenting that in the physician's opinion the appropriate circumstances, as outlined in sentence one of this paragraph, existed; and such certification must also indicate the procedures used in providing such services. However, when medical services not routinely related to the uncovered abortion service are required, the utilization of an uncovered abortion service shall not preclude the recipient from receipt of medical services normally available through the Medical Assistance Program.

6. Medical Care and Any Other Type of Remedial Care

b. *Optometrists' Services* (Limitations apply to both categories)

1. *Optometric Benefits*

a) Optometric benefits are limited to eligible recipients under the age of 21.

2. *Vision Care Service*

a) Coverage is limited to those procedures listed on a benefit schedule for vision care services. These procedures are included in the following categories:

1) Diagnostic Services

2) Prescription Services

3) Services to frames and lenses

b) All eyeglasses, other than those prescribed for amblyopic or post-surgical patients, must be pre-authorized by the Program.

c) Pre-authorization is also required for certain replacement of frames and lenses, and/ or replacement of parts.

State: VERMONT **Submittal No.: 79-22**
ATTACHMENT 3.1-A
Effective 1-1-80 **Page 2a**

Item 5. Physicians' Services

A. Physician's services for treatment of mental, psychoneurotic or personality disorders, as defined in the American Psychiatric Association's "*Diagnostic And Statistical Manual* —Mental Disorders", are limited to a maximum of $500.00 in a calendar year. This limitation does not apply to physicians' services provided while the individual is a hospital inpatient, nor to home health, mental health clinic, and hospital outpatient services.

Extensions to the $500.00 limitation may be granted if there are compelling reasons to do so; e.g., abrup termination of treatment would place the recipient in serious and immediate jeopardy, discontinuation of care would substantially cancel improvement in the patient's mental condition, or no alternative mode of treatment is available. Requests for extensions must include the medical and psychiatric history of the patient, recommended course of treatment, anticipated number and frequency of services, and such other relevant information as will fully substantiate the request.

B. Physician services directly related to experimental treatment procedures are specifically excluded. The following types of organ transplants are considered to be experimental treatment procedures and, therefore, not covered: heart, lung, spleen, liver, pancreas, endocrine organs, brain, stomach, eye, appendages, thymus.

C. Reimbursement can be made for one physician visit to the same recipient in a nursing home (not an ECF) in a calendar month on the presumption that such a visit is medically necessary for the proper management of a person whose condition requires him to reside in such a home. Further visits

are reimbursable only if the claim submitted by the physician has adequately substantiated the need for more frequent visits to the patient.

Where it is established that a physician visited only one patient on a particular trip to a nursing home, reimbursement will be based on an amount which may not exceed the normally applicable customary and prevailing charge for routine follow-up house calls. Since this level of reimbursement already takes into account that the physician may have some additional expense in terms of travel to the nursing home and time away from his office, no additional charge will be recognized except in extraordinary circumstances. All other claims will be treated as multiple visit situations and the reasonable charge allowance will be based on the customary and prevailing charges for routine follow-up office visits.

D. Cosmetic surgery or expenses incurred in connection with such surgery is not covered. Cosmetic surgery encompasses any surgical procedure directed at improving appearance (including removal of tattoos), except when required for the prompt repair of accidental injury or the improvement of the functioning of a malformed body member. For example, the exclusion does not apply (and payment would be made) for surgery in connection with treatment of severe burns or repair of the face following an auto accident, or for surgery for therapeutic purposes which coincidentally serves some cosmetic surgery should be requested from the Department's consulting physician.

E. Sterilization of either a male or female recipient is covered only when the following conditions are met:

1. The recipient has voluntarily given informed consent and has so certified by signing the consent form included in DHEW Publication No. (OS)79-50061 (female), or (OS)79-50062 (male), November, 1978 and provided by the Department of Social Welfare.

2. The recipient is not mentally incompetent.

3. The recipient is at least 21 years old at the time consent is obtained.

4. At least 30 days but not more than 180 days have passed between the date of informed consent and the date of sterilization except in the case of premature delivery or emergency abdominal surgery. In those cases, at least 72 hours must have passed between the informed consent and the operation.

Operations or procedures performed for the purpose of reversing or attempting to reverse the effects of any sterilization procedure are not covered.

F. A hysterectomy is not covered if:

1. It was performed solely for the pupose of rendering an individual incapable of reproducing.

2. There was more than one purpose to the procedure, it would not have been performed but for the purpose of rendering the individual permanently incapable of reproducing.

Any other hysterectomy is covered only if the recipient has been informed as to the nature of the operation and its consequences and has given consent by signing the Hysterectomy Consent Form (DSW 219C).

G. Providers will be reimbursed by Medicaid for abortions performed only if:

1. A physician, on the basis of professional judgement, has certified in writing that the abortion is necessary because the life of the mother would be endangered if the fetus were carried to term.

2. Two physicians, at least one of which has neither direct nor indirect financial interest, on the basis of their

professional judgment, have certified in writing that severe and long lasting physical health damage to the mother would result if the pregnancy were carried to term.

3. Such procedures are for a victim of rape or incest when such rape or incest was reported within 60 days of incident to a law enforcement agency or public health service, and such report is documented to the Department.

4. The abortion is performed to terminate an ectopic pregnancy.

H. Routine payment will not be made for the following procedures. Written justification will have to be made by the physician and approved by the Division of Medical Services before payment will be authorized. The procedures were identified because each fits into one or more of four specific categories:

1. New procedures of unproven value.

2. Established procedures of questionable current usefullness.

3. Procedures which tend to be redundant when performed in combination with other procedures.

4. Diagnostic procedures which are unlikely to provide a physician with additional information when they are repeated.

Identification of these procedures was made through the Medical Necessity Program begun by Blue Shield with the assistance of the American College of Physicians, American College of Radiology and American College of Surgeons. Also participating, was the American Academy of Family Practice, Council of Medical Specialties, American Hospital Association and American Association of Medical Colleges.

The surgical procedures are:

1. Ligation of internal mammary arteries, unilateral or bilateral—the tying of the mammary arteries located in the chest.

2. Radical hemorrhoidectomy, whitehead type—extensive surgical excision of hemorrhoids.

3. Omentopexy (portal obstruction)—surgical fastening the omentum (a tissue extending from the stomach to other organs in the abdomen) to establish a more efficient blood flow between the stomach/intestines and spleen through (via) the liver.

4. Kidney decapsulation, unilateral and bilateral—the surgical removal of a fatty or fibrous structure which covers all or part of the kidney.

5. Perirenal insufflation—injecting air around the kidneys for x-ray visualization of the adrenal glands, located on top of the kidneys.

6. Nephropexy—the fixation or suspension of a floating (not attached) kidney.

7. Circumcision, female—the incision of the fold of the skin over the clitoris.

8. Hysterotomy—cutting into the uterus for non-obstetrical reasons from the vaginal approach.

9. Supracervical hysterectomy—the uterus is removed, leaving the cervix in place. In addition, the ovaries and/or fallopian tubes may be removed.

10. Uterine suspension—the fixation of suspension of the uterus to the vagina or abdominal wall by shortening ligaments attached to the uterus.

11. Uterine suspension with presacral sympathectomy—same as above but with the interruption of the sympa-

thetic nerve pathways in front of the sacrum. The sympathetic nervous system stimulates, among other parts, the reproductive system. The sacrum is the bone located just below the lower back region and is composed of a series of fused vertebrae.

12. Hypogastric or presacral neurectomy—the excision of part of the hypogastric or presacral nerve (plexus).

13. Fascia lata by stripper when used to treat lower back pain—the repair of the sheath of connective tissue which covers or binds body structures together.

14. Fascia lata by incision when used to treat lower back pain—same as above, but the fascia is incised and removed.

15. Ligation of femoral vein, unilateral and bilateral when used to treat post-phlebitic syndrome—the tying of the famoral vein in the thigh for post phlebitic syndrome (post-thrombotic (clot) complication which includes, but is not limited to destruction of the valves of the deep veins of the legs).

16. Excision of carotid body tumor when used to treat asthma—the removal of a round mass located on or near the carotid artery in the neck.

17. Sympathectomy, thoracolumbar, unilateral or bilateral when used to treat hypertension—the interruption of some portion of the sympathetic nerves in the back.

18. Angiocardiography, multiplane supervision and interpretation only in conjunction with cineradiography. This is similar to 17. above except x-rays are taken from more than one angle.

19. Angiography-coronary, unilateral, selective injection, supervision and interpretation only, single view

unless in an emergency. This procedure photographs the coronary arteries of the heart. It uses a single view x-ray after an injection of a radiopaque substance. It is used on coronary patients or as a diagnostic test to determine the conditions of the coronary vessels.

20. Angiography extremity. This procedure photographs the arteries of the arms and legs. The test is used to determine the presence of clots, ruptures or constrictions in the arteries.